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Biological & Medical Serials

A QUARTERLY JOURNAL

OF

SKIN AND VENEREAL DISEASES.

L. DUNCAN BULKLEY, A.M., M.D.

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Fig. IV.

FIG. IV. A large vesicle and two smaller ones. The large vesicle is of a few days duration, and the entire section shows changes which are described in the text. Pus cells are present in great number in the liquid of such a vesicle, and in the structures directly beneath it. Here the origin of the vesicle *A* from the papilla beneath it is very distinct. Also the origin of the vesicles *B* and *C*, from their respective papillæ *B'* and *C'* is well marked. The vesicles *B* and *C* have become united by rupture of previously separating bands. Part of the corneous layer has here become removed.

In all the drawings the corneous layer is represented by non-granular, non-nucleated cells, with the exception of a few cells in Fig. III., but in reality there was not this sharp distinction in the sections. Where the corneous layer is so thick as in these specimens, very many of the cells have a more or less distinct nucleus, and occasionally some granular matter, and they color in carmine. Only when the corneous layer is thin, is the line of separation well defined.

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ARCHIVES OF DERMATOLOGY.

JULY, 1877.

Original Communications.

POMPHOLYX.

[CHEIRO-POMPHOLYX (HUTCHINSON): DYSIDROSIS (TILBURY FOX.)]

BY A. R. ROBINSON, M.B., L.R.C.P.&S., EDIN.

Special Pathologist to the New York City Asylum for the Insane.

HISTORY: In the American Journal of Syphilography and Dermatology, January, 1873, Dr. Tilbury Fox, of London, published the first article on this disease. He named the affection dysidrosis, and stated that "it is characterized by the retention in the follicles of the skin of sweat rapidly and freely secreted. The disease bears the same relation to the sweat follicles that acne does to the sebaceous glands. The retention of the sweat and distension of the follicles are followed secondarily by congestion of the sweat follicles, by the formation of bullæ, maceration of the epidermis and perhaps more or less dermatitis. The sweat glands are frequently seen dilated here and there over the affected surface, and never seem to recover their proper character. The origin of the disease is a distension of the sweat duct, not only of its superficial, but also of its deeper part, and this is followed by the continued distension of the duct, and the aggregation and coalescence of the vesicles. It depends on a paresis of the nerve supply of the sweat apparatus, whereby its functions become deranged."

Mr. Hutchinson, of London, a surgeon of unusual attainments and of high and well-earned reputation as an original and trustworthy clinical observer and pathologist, published, in 1876, in his "Illustrations of Clinical Surgery," a drawing of this disease to which he gave the name cheiro-pompholyx. He made no mention of Dr. Fox's article, and said he did not think any correct clinical description of the disease had been previously given. He consid-

ered the contents of the vesicles or bullæ to be serum, and the disease itself a neurosis. His description of the disease will be given further on in this article. Upon the publication of this article, Dr. Fox (Lancet, April 15, 1876, page 553) attacked Mr. Hutchinson for not referring to his article on dysidrosis and for not having recognized his assumed claims as the first to have described the disease. He drew attention to the similarity in their descriptions of the disease, and in the use of certain terms such as sago-grain appearance, a coincidence which he imagined to be due to Mr. Hutchinson's familiarity with his (Dr. Fox's) paper. He considered Mr. Hutchinson had failed entirely in comprehending the nature of the disease, "which is an affection of the sweat glands and consequently the contents of the vesicles or bullæ are sweat and not serum as maintained by Mr. Hutchinson." It was shown, however (Lancet, April 22, 1876, page 618, and April 29, 1876, page 639), that Mr. Hutchinson was quite familiar with the disease years before Dr. Fox had recognized its special character, and that in fact the patient from whom Dr. Fox obtained his first impressions of the disease had been fifteen years under Mr. Hutchinson's observation before Dr. Fox saw her. This was the same patient of whose hands a drawing was given in the "Illustrations of Clinical Surgery." This drawing had been used by Mr. Hutchinson for years previous to the appearance of Dr. Fox's article, to illustrate his lectures upon this disease given by him at the London Hospital and at Blackfriars. There is therefore no ground whatever for Dr. Fox's claim to priority in the matter, neither was Mr. Hutchinson, to use his own words, indebted to Dr. Fox "for even a sago-grain." As to whether it is a disease of the sweat glands or not will be shown conclusively when I treat of the nature of the disease later on, and give the result of my own studies on the subject.

Whilst, therefore, the credit of having first recognized and lectured upon the disease belongs to Mr. Hutchinson, it is nevertheless to be regretted that he did not sooner publish his views and thus not only have done justice to himself but also have aided science.

Through the kindness of Dr. Fox, who showed me several examples of the affection at his clinic in University College Hospital, and drew my attention to its characteristic diagnostic characters, I was acquainted with the disease whilst studying in London, and in this city I have seen a considerable number of mild cases of the affection. I have had also a most excellent example of the disease in a patient who has been for some time under my observation and care, and from whom the material was obtained which now enables me to discuss the disease and to decide as to its true nature.

Symptoms: I will give Mr. Hutchinson's and Dr. Fox's description of the clinical characters of the disease in preference to one by myself, partly because they are more familiar with its symptoms than I am, and consequently their descriptions are of more value; and partly because I wish to show by them that the case whose

history and symptoms I will afterwards relate, and from whom portions of skin were removed for microscopical study, was a most excellent example of this disease.

Mr. Hutchinson's description of the affection is briefly as follows: The more severe forms which I have seen have always been in women, and usually in association with a highly nervous temperament. The disease appears to be characterized by rapid and symmetrical development, by tendency to spontaneous cure, and by the liability to recur over and over again in the same individual. The hands are the parts first affected; the feet come next; and in a few instances a rash appears over the rest of the body. In the majority of cases the hands alone suffer, and in all they are the parts most severely affected. A tendency to spontaneous absorption of the fluid contained in the vesicles or bullæ, even when the latter are very large, is a very remarkable feature. It is not connected with any local cause nor is it influenced by local treatment. The eruption begins with intense burning and itching on some part of the hand, usually between the fingers. After a short time—a few hours or a day or two—there are seen, deeply placed in the skin, small accumulations of clear serum, looking like sago-grains. These are perfectly transparent and not unfrequently resemble the vesicles of scabies sufficiently to excite suspicion. They differ, however, from those of scabies in being much more deeply placed, having flatter tops, in being usually closer grouped together instead of scattered, and in the entire absence of burrows. In some it occurs during hot weather, but in most instance no cause can be given for its occurrence. Those who have had it once will very probably have it again, and several of the facts in its clinical history coincide pretty nearly with what is true of herpes of the lips and of the prepuce. I do not recollect even to have seen a well-marked example of it in a patient under the age of puberty, nor in a very old patient. The tendency to speedy and spontaneous disappearance, leaving the skin quite sound, supplies a feature of positive difference from eczema, of which the indefinite duration and the tendency to persist and become aggravated are such marked characters. Symmetry, spontaneous cure and liability to relapse are its clinical characteristics. In minor degrees the affection is tolerably common. Many, indeed perhaps most of us, are liable at times in connection with slight derangements of health, or possibly with exposure to the sun, to the occurrence of a very irritable sago-grain eruption on the sides of the fingers. The so-called sago-grains are deeply placed effusions of serum, but in a large majority of cases they undergo spontaneous absorption after a few days, and not even peeling of the epidermis results. They never by any chance result in eczema. In those liable to this slight affection the disease is prone to recur repeatedly at intervals perhaps of a few years. More severe cases, in which the vesicles coalesce and develop into bullæ, are not very uncommon, their subjects being, so far as my experience has gone, almost invariably young women. In several of the most severe cases which I have witnessed the eruption was attended by ex-

treme depression of spirits. Although the eruption always shows a tendency to spontaneous disappearance, yet, in some instances, it may last a couple of months and require treatment. In one case under my care the liability to attacks had extended over thirty years. In this case the vesicles always broke, and a state much resembling that known as psoriasis palmaris resulted in the palms, whilst on the sides of the fingers it looked more like eczema.

Dr. Fox's description of the disease coincides very closely with that of Mr. Hutchinson's, an occurrence not to be wondered at since the same patient furnished both of them the best example of the affection perhaps that they have ever seen. Independently of this patient, however, Dr. Fox has very carefully studied the clinical characters of the disease in a great number of patients, some of whom he kindly showed me and explained to me his views of the disease. Dr. Fox says "the disease, in its slightest form, is confined to the hands, occurring in the interdigits, over the palm and along the sides of the fingers, and on the palmar surfaces. It makes its appearance in those who habitually perspire freely, and the patients feel weak and depressed. The eruption consists of minute vesicles deeply imbedded in the skin, and are at first isolated. They do not readily burst, and when a few days old look like sago-grains imbedded in the skin. The vesicles afterwards become more distended and raised. They are not pointed, but oval, eventually become faintly yellow in color, and run together and form bullæ. The hand is then stiff and painful. If the eruption is left undisturbed, the fluid is partly absorbed, partly evaporated, the cuticle then peels off, leaving a non-discharging, reddened, exposed derma. In some of the milder cases only vesicles are formed. When disappearing altogether from the hand the palm is left harsh and slightly scaling. In some cases a red, dry, slightly scurfy, painful surface is left behind and becomes chronic. No patient is well who has this disease. In severe cases there is great nervous debility."

From this curtailed description of Dr. Fox's, it is readily seen that both Dr. Fox and Mr. Hutchinson are describing the same disease, though their views as to its nature are so widely different, as has been already stated in giving the history of the affection.

And now to the history of my patient.

L. S., born 1846, is of medium height, light complexion and weak muscular development. In 1849, one of his thighs was fractured twice, after which time his mother says he was sickly and nervous for a number of years. In 1866 was married, and six children have been born to him since that time, three of whom are dead and three living. Two children (boy aged 5 months and girl aged 2 years) died of spinal meningitis, and one (a female child) died of pemphigus. The pemphigus commenced on the ninth day after birth, as a small blister the size of a pea, on the right side of the abdomen, below the umbilicus. Within twenty-four hours the bullæ had reached the diameter of one inch. A few days later, another appeared on the left side of the neck, which rapidly increased in size and attained a length of three or four inches. At the same

time smaller bullæ appeared on both temples near the eyes, in the armpits, and over the rest of the body. On the 12th day (3d of the sickness) the pulse was 140 and temperature 103° F. On 14th day pulse 120 and temperature 102½. It lived fifteen days during which time its bowels were regular and it nursed well until the 15th day. The bullæ left a raw, sore surface behind. Luke-warm water was used for bathing it. This was the fifth child of the family. The sixth child has had eczema capitis. In February, 1871, he received an appointment in the New York fire department, since which time he has always been connected with this service. Previous to his marriage a few vesicles would appear occasionally on his hands, but the first severe attack was in July, 1871. This attack lasted about two months, appearing both on the hands and feet, but commencing on the hands. The feet were not attacked until about one month after the hands. The eruption occupied the entire palms of the hands, the palmar aspects and sides of the fingers, and a portion of the plantar surfaces of the second phalanges. On the feet it appeared only on the soles, from which it removed the entire common layer of the epidermis. According to the patient's statement, the eruption during this attack consisted of vesicles, at first deeply placed and isolated, but afterwards frequently uniting and forming bullæ. The vesicles almost always dried up, their contents being absorbed without a rupture of the walls taking place. Even the large bullæ generally dried up without rupturing. If large areas of the skin were bereft of all that part of the epidermis above the vesicles or bullæ, *i. e.* the corneous layer of the skin, all that was observed beneath was a reddish, smooth surface. Various applications were made to the hands in the treatment of the disease (it having been regarded as an eczema), but no benefit was derived from their use. He then ceased treatment and the disease disappeared spontaneously, having lasted about two months. In 1872 he was bitten in the right hand by a dog, and the dread of hydrophobia made him very nervous and depressed in spirits. In February, 1877, the second severe attack occurred, these isolated vesicles appeared every now and then during this interval of nearly six years. During this last attack, which still continues (June 15th), he has been under my care. The eruption had lasted about three weeks when I first saw him. It had commenced on the palms of the hands near the wrist, and spread over the entire palms and between the soles and on the palmar surfaces of the fingers. When I saw him the majority were seated between the fingers. The eruption has changed but little in its mode of appearing and in its course since I first saw him. An outbreak is always preceded by a tingling, burning sensation in the parts, and the patient is more than usually depressed and nervous. The eruption appears as small clear vesicles, deeply placed in the skin. They may be single or collected in groups of two, four or more. Very frequently the vesicles forming a group are all of the same age and size. The eruption always was symmetrical, and I have very often observed that exactly corresponding parts of the hands or feet became affected at the same time. If but a single vesicle existed it almost invariably dried up. Where there was an

aggregation of vesicles they were at first isolated, but afterwards frequently united and formed a bullæ. If then the liquid was absorbed, the skin covering them became very hard and dry. I stated that the vesicles appeared to contain a perfectly clear liquid, but this afterwards generally became more or less opaque, though scarcely ever yellowish in color. This latter occurred only when large bullæ were formed and the liquid slowly absorbed, *i. e.*, in other words, it was observed only when the bullæ were of several days' standing, and, as will be seen afterwards, was owing to the number of pus cells present in the liquid. The vesicles were never seen to have a red base. The walls of the vesicles appeared of a darker color (from compressed cells) than the surrounding skin or the contained liquid. This really made the vesicles look like sago-grains imbedded in the skin. The vesicles gradually become larger, and raised. Isolated vesicles in the palms of the hands seldom became raised above the level of the skin previous to absorption. Where they appeared in groups they always became raised above the general surface, as also most of the isolated vesicles between the fingers. They were never pointed, but always had a more or less flattened top. After the absorption of the contents or rupture of the vesicles or bullæ, a reddened surface (on account of the thinness of the epidermis) was left behind. At no time was there a cracked or discharging surface or any appearance resembling that of eczema in this region. Occasionally the eruptions spread peripherically, especially in the palms of the hands. There has been no change in the appearance of the vesicles since I first saw him, but at present the disease is not so severe, the eruption consisting principally of isolated vesicles and but very few bullæ. Occasionally, however, an "outbreak" occurs lasting two or three days. Then the eruption presents more of the character it had in an earlier period of the disease. The feet are also affected, but only in a slight degree, a group of vesicles appearing occasionally here and there. Their appearance is always preceded by a tingling in the part. They appear symmetrically, and often on exactly corresponding parts. There has never been any accompanying eruption on the other parts of the body. I have tried various local applications and naturally without any benefit except keeping the parts soft. Internally he has taken iron, strychnine and pure phosphorus, and evidently with some benefit. To-day I have prescribed Fowler's solution of arsenic in five drop doses, three times a day.*

The patient is exceedingly nervous and depressed in spirits. He was so nervous that he hesitated several weeks before allowing me to remove a second portion of skin from his finger. Even then I was obliged to benumb the part with ether spray before using the knife. He says his forearms and hands feel benumbed and "sleepy," especially in the morning, if he keeps them elevated above the bedclothes. He sweats a great deal, yet the hottest day in summer is not too hot for him.

Before proceeding to give a description of the mode of forma-

* July 12th. After taking the arsenic one week the eruption disappeared entirely, but reappeared seven days after ceasing its use.

tion and structure of the vesicles and bullæ in this disease, I will give a short account of the clinical characters and structure of the eruption in the different skin diseases in which vesicles or bullæ occur; in order the better to be able to decide the question as to whether pompholyx is a separate and distinct disease, or only one of the other previously known vesicular or bullous diseases appearing in a locality whose anatomical characters and situation influence its development and course in such a manner that it receives additional or special characters.

Vesicles or bullæ occur in sudamina, miliaria, pemphigus, herpes, lichen, lupus, eczema and erysipelas.

In sudamina, the liquid composing the vesicle is enclosed between the layers of the stratum corneum; both the base and summit of the vesicles being formed of the cells of this layer. The liquid is acid or neutral, and is nothing but retained sweat, the disease itself being merely the retention of sweat in the corneous layer, either from rigidity of the walls of the sweat duct, or from some obstruction to its free passage to the surface of the skin. The vesicle always consists of a single chamber. The disease generally appears on the neck, about the shoulders and on the trunk as clear watery elevations, which quickly dry up and are followed by slight desquamation. The disease is not symmetrical in its appearance, is not preceded by nervous symptoms or pain in the affected part, in fact bears no resemblance clinically with pompholyx.

Miliaria is supposed to be only inflamed sudamina, and in this case the contents of the vesicles are alkaline and not acid. The structure of the vesicles remain, however, the same as in sudamina. I have my doubts as to the correctness of this explanation of miliaria, and hope before the present summer passes away to further investigate this subject.

In pemphigus the eruption consists of blebs seated upon an inflamed base, which is quickly covered over by the enlarging bullæ. The latter are generally isolated, of a round or oval form, elevated above the general surface and reach their maximum of size in a few hours. The liquid is at first alkaline and transparent; but afterwards becomes turbid and acid. It is serous in nature, being derived direct from the blood. The fluid within the bullæ is sometimes absorbed; in which case the latter shrivel up without bursting. At other times the blebs burst, and a slight ulceration takes place where the eruption was seated. Sometimes rupture of a blood-vessel occurs and the contents of a bleb becomes sanguinolent. The eruption generally occurs in successive crops, and is accompanied with slight smarting and soreness in the part attacked. The disease rarely attacks the head, palms of the hands or soles of the feet in adults, although, according to my experience, pemphigus appearing in children within the first few days of extra-uterine life generally shows itself on the two latter localities. In the bullous syphilide the contents are more pustular than serous, and dry to a thick scab. According to Haight (Sitzungsberichte der K. K. Academie in Wien, 1868, Bd. lvii.),

the summit of the bullæ in pemphigus is formed from the corneous layer whose cells do not color in carmine, and its base is formed from the mucous layer over which a double layer of flat cells lies. "The cells of the under mucous layer are somewhat elongated, those of the upper layer flattened, with their long axis parallel to the corium surface. The papillæ are somewhat swollen and higher, penetrated by fine spaces, and their blood-vessels insignificantly enlarged. From this drawing out of the cells of the malphigian layer the bulla is at first fan-shaped, but afterwards it is simple, the effused liquid filling the entire bullous space."*

Herpes is characterized by the appearance of vesicles or bullæ seated always upon an inflamed base. They are collected into groups of two or more vesicles or bullæ which are distinct from each other. The vesicles of a single group are generally of the same age, and they do not as a rule burst; but dry up and the contents disappear by absorption. The liquid is at first clear and alkaline, or neutral; but afterwards becomes opaque and acid. The eruption is preceded and accompanied by burning pain, heat and tension in the affected part. The disease is generally unilateral. The local forms of herpes resemble each other very closely, differing only in the mode of arrangement and number and size of the vesicles in the groups. In the vesicular syphilide the vesicles are seated on a dark base, are met with most frequently on the body and limbs, and probably never on the feet and hands alone (Fournier). In herpes zoster a perpendicular section through a bulla shows, according to Dr. Haight (l. c.), the corneous layer raised, the corium surface exposed, and between them a flattened compartment containing the effused liquid. "The corneous layer consists of several layers of flattened cells without nuclei, and has on its inner surface one or more similarly flattened cells of the upper malphigian layer containing nuclei. The cavity is divided into several large spaces by thick bands, which spaces are again subdivided by a fine network. The thicker bands lie stretched perpendicularly between the corneous layer and the interpapillary part of the corium. They consist of several rows of closely-packed spindle-formed cells, having a nucleus which colors deeply in carmine. In every space bounded by these bands a papilla projects, and the number of spaces in a bulla depends upon the size of the latter and the number of papillæ. The spaces are covered by a network which passes in every direction, and is formed partly from spindle-shaped nucleated cells, and partly from nucleated cells provided with several branches, and also from fine fibres. Epithelial cells are attached to the surface of the corium and between them small round cells similar to those lying in the corium. In the loose corium tissue a few round, granulated cells about the size of white blood corpuscles are found. The nerve fibres in the corium are swollen, the mark substance softened and the axis cylinder lies eccentrically." I cannot accept without fur-

* In the description of the formation of the vesicles or bullæ in pemphigus, herpes, erysipelas and burns, I quote the statements of other observers, as I have not studied the subject myself.

ther proof than that derived from the section of a single nerve trunk, that the above-mentioned condition of the nerves is always present in herpes, or that it has anything to do with the production of the eruption. I am rather inclined to regard the condition found by Dr. Haight in his section as a secondary and occasional condition, produced by the excessive amount of liquid in the part and not as a cause of the herpetic eruption. The number of the thicker bands also cannot depend upon the size of the bulla but only upon the number of papillæ affected.

In erysipelas bullæ occasionally occur, but the clinical character of the disease is so well understood and so entirely different from that of pompholyx that it is unnecessary to enter into the description of the formation of the bullæ in this disease, further than to state, that they closely resemble those of herpes, with the addition, that there is extensive infiltration of the corium with serum and round cells.

In eczema vesiculosum the vesicles appear upon a swollen and reddened base, the vesicles burst and the secretion dries to crusts, under the removal of which, a moist, red weeping surface is seen. The disease can attack any part of the cutaneous surface, is of uncertain duration, and when seated on the palms of the hands produces a rough, painful, cracked surface, which shows but slight tendency to heal without proper treatment.

According to Hebra's article (Sitzungsberichte der K. K. Acad. Wien, 1867), in vesicular eczema the papillæ are lengthened and lengthened by infiltration with cells and liquid. The connective tissue corpuscles of the papillæ are large and soft and increased in number. Numerous spindle-shaped cells stretch from the papillæ into the mucous layer, press the cells of the latter from each other, and reach even as far as the cutaneous layer. There often build in the mucous layer a thick network, within which lie the epithelial cells. If the process stops at this stage only a papule is formed; but if it passes on to the formation of vesicles, then there is a greater increase of cells in the papillæ, the superficial cells of the mucous layer become swollen and horny, and the epidermis is elevated. According to the quantity of liquid passing from the papillæ to the cutaneous layer will be the size of the vesicle.

In vesicles from lesions of the first grade the papillæ are wider and longer, and the papillary blood-vessels three times their normal size. Over the changed papillæ the epidermis is raised, and on the inner surface of the latter a single layer of contracted epithelial cells lies, whilst between this layer and the corium thin fibres are spread out. If the exudation is excessive these fine fibres become torn and are found clinging to the under surface of the epidermis and upper surface of the corium. Between these fibres the shrunken cells of the mucous layer appear, and a few round cells are present within the vesicle.

As the term hydroa has not as yet been employed to represent any special vesicular or bullous disease, but rather anomalous forms of pemphigus or herpes, and as the anatomical structure of

the vesicles has not been studied by any miscroscopist, it is unnecessary to here reproduce the description of the disease as given by those authors who have made use of the term, further than to state, that as regards location and clinical characters there is no resemblance whatever between this disease and pompholyx, except the presence of vesicles in both affections.

In studying the nature of the liquid in the vesicles and bullæ of pompholyx the contents of the small vesicles were examined microscopically after mixing them with serum obtained from a frog's eye, whilst that contained in the bullæ was examined without the addition of any indifferent fluid. The contents of the small vesicles and of all vesicles of only a few hours' existence were examined in serum, as without this procedure the liquid dried up before it could be properly examined. In the very earliest stage, i. e., during the first few hours of the existence of a vesicle, the contents contained no formed elements ; but in a later stage small, round bodies of the size of lymph corpuscles were to be found, and the number present was as a rule proportionate to the age of the vesicle or bulla. It is owing to the presence of these bodies in the liquid that it frequently assumes a yellowish color in the later stage of the vesicles or bullæ. In the earlier stage these bodies show amœboid movements similar to those observed in white blood corpuscles. They color in carmine and hæmatoxylin. They are, in fact, nothing else than out-wandered white blood corpuscles. Their presence pointed to the probability of the liquid in which they exist having had its origin in the blood, i. e., that it was effused serum.

Examined chemically the contents were always slightly alkaline or neutral, and never acid ; and although sweat is generally acid, yet in this case that fact would not have been sufficient to have proven that the liquid was not sweat, and consequently that the disease was not an affection of the sweat glands, since the sweat also was neutral. The sweat in the immediate neighborhood of a group of vesicles, as well as on other parts of the hand, was found to be neutral every time I examined it. In the later stages the liquid frequently becomes acid. Testing, however, with nitric acid to decide as to the serous or sweat nature of the contents, gave decisive results. An albuminous coagulum was immediately produced, with the nitric acid in the usual proportion obtained from serum, whilst testing the sweat in the same manner, not a trace of a precipitate was observed. Thus the disputed point between Mr. Hutchinson and Dr. Fox was clearly decided by this simple test, and it is surprising that neither of the gentlemen engaged in the controversy thought of this means of deciding the question, or of defending their position, and more especially Dr. Fox, as he was the attacking party. Before coining a new name for a disease, and especially before making use of a term so suggestive as dysidrosis, one certainly should enter into a thorough study of its real nature, and thus avoid the error which so often follows supposition or mere guess work. Everything in pompholyx points against its being an affection of the sweat glands ;

Fig. I.

Fig. I. represents a very early stage of the vesicle formation. The vesicle a has the origin from the interlacings of the papilla and closely beneath it. The contents of such a young vesicle are clear serum, and no round cells are to be seen either within the papilla or between it and the vesicle. The cells between it and the vesicle are paler in color and somewhat changed in form.

Fig. II.

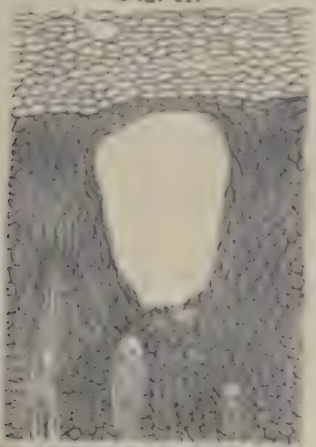


Fig. II exhibits a later stage than Fig. I. The cells in the vicinity of the fluid become more pressed and flattened as the vesicle increases in size. The corneous layer is slightly macerated, and the cells detached in two places, in this figure. The liquid in the vesicle came from the papilla situated below and slightly to the left of the vesicle. The woodcut does not show that so clearly as appears in the section or in my drawing on paper.

therefore there was all the more necessity for previously examining chemically the nature of the contained liquid, before claiming to be the discoverer of a hitherto unrecognized disease of the sweat glands.

Thus the ordinary test for albumen would have decided the question had it been employed, and in my hands did decide, that as far as the contents of the vesicles and bullæ were concerned, *the sweat glands had no part whatever in their production.* Hence the term dyshidrosis, for this disease at least, cannot be any longer employed and consequently must be stricken from the nomenclature of skin diseases or used synonymously with sudamina.

In laying so much stress upon this test with nitric acid I do so with a full knowledge of the experiments of Leube (Centr. f. d. Med. Wissen. 1869), by which he proved the occasional excretion of albumen by the sweat glands. The quantity found was always very small, and required special manipulation to show its presence. These experiments, therefore, have no weight in the present question.

Histology. In order to study the origin, structure, mode of formation, course, etc., of the vesicles, portions of skin containing in all thirteen separate vesicles in different stages of development, were taken from two different parts of the fingers. There was an interval of about four weeks between the time of the first and second cutting. The excised pieces of skin were washed with water to remove any adherent blood, and placed, first in Müller's liquid for two weeks, and afterwards in alcohol, until they became sufficiently hardened for making thin sections. The sections were first examined in glycerine without previous staining, and a second time examined in the same liquid, after colouring them with carmine. From the large number of vesicles examined I was enabled to trace the whole process from its commencement as a small effusion of serum, to its termination by absorption of the liquid, or escape of the contents by rupture of the cells covering the vesicle.

The liquid comes from the blood vessels of the papillæ, and if the vesicle is very small the entire liquid comes from a single papilla. It passes through and between the cells of the lower malpighian layer and collects in different situations in different vesicles. There is no definite restricted location for the first collection of the liquid, though the rule is for it to collect in the upper malpighian layer at a distance of two or three layers of cells from the lower surface of the corneous layer. Sometimes, however, it collects immediately beneath the corneous layer, between this layer and the upper surface of the cells bordering on the stratum corneum, i. e., between the malpighian and corneous layers of the epidermis. If but a single papilla is affected, that is, if the liquid comes from the blood vessels of a single papilla, the vesicle has but a single chamber (see figure 11). The liquid at the place of collection presses the cells apart in every direction. On this account the cells become changed in form. They are gradually flattened and drawn out, more especially those cells which line the sides of the vesicle. The more the vesicle increases in size the more the cells are flattened out, until they at last appear as fibres in which no nucleus is

visible. The cells forming the summit of the vesicle are not so much flattened, and even when the vesicle bursts and the liquid escapes to the free surface, this occurs, not so much by a flattening out of the cells forming the covering, as by a rupture and separation of these structures. In fig. 4, where the vesicle has attained a large size, the cells of the malphigian layer immediately beneath the stratum corneum will be seen to still maintain much of their original shape. The cells of the corneous layer at an early stage of the vesicle are affected, and in different places over the vesicle become detached from each other, leaving spaces filled with a watery fluid. On this account a portion of the corneous layer is frequently removed even when the vesicles do not burst. The blood-vessels in the papillæ are at first but slightly changed, and but few round cells are found outside of their walls; but in the later stages they become more dilated; though they seldom become what one would call widely dilated. In these later stages also out-wandered round cells appear in greater number in the papilla, and passing in the same direction as the effused serum, they are found also in the malphigian layer and within the vesicle. Sometimes the collection of those round cells is so great in the malphigian layer that it is impossible to distinguish the form and outlines of the cells forming the lower two or three cell-layers of this structure (see fig. 4). The serum in passing from the papilla to the place of collection causes marked changes in the form and appearance of the cells between which it passes. They become drawn out, paler in color, and less granular in appearance from the imbibition of serum. Generally the change of form and appearance is so great that their outline becomes indistinct, and only occasionally is the nucleus to be seen. Sometimes they appear to reach from the corium to near the corneous layer. It is, however, frequently impossible to see where they terminate, as the malphigian layer has more the appearance of being composed of long bands or fibres than of cells.

Thus we see in the case of a single small vesicle that the change in the parts depends upon the age of the vesicle and the amount of fluid effused, consequently a vertical section of such a vesicle would show different appearances according to the period at which it would be examined. In the earliest stage only the cells of the lower malphigian layer would be drawn out, and those cells surrounding the liquid slightly flattened. But few round cells would be seen, and the blood-vessels of the papilla would be scarcely changed. The number of layers of cells from the upper malphigian layer lying be'twen the vesicle and the corneous layer would be greater than in a later stage. This of course would not be true of those cases in which the liquid at the commencement is situated between the malphigian and corneous layers.

In the later stages, the vesicle is larger, the cells more flattened, their margins more indistinct, the blood-vessels more enlarged, and a greater number of round cells present in the papillæ, malphigian layer and vesicles. The liquid will also lie nearer the corneous layer and the corium (as the vesicle increases in size in all directions),

Fig. III.

Fig. III shows the simultaneous formation of three vesicles from three adjoining papillæ. The fourth separating the vesicles corresponded to the intermediate papilla. Separation of cells in the superposing basal line commences above, whilst that between B and C is still intact. The swelling and clustering out of the cells of the Malpighian layer is well shown in this drawing. In *A* pseudo-basal segmentation and mitosis are present in the papilla, whilst that part of the Malpighian layer lying between the papilla and the vesicle on the right is so because the space of a papilla not seen. Other drawings also show the height of the vesicles and the more superficial papillæ, but a drawing of this stage was made necessary to show the absence of the separation of the cells in the beginning of the process and of their more abnormal size.

and the corneous layer will be more broken up. Thus it is clear that from a single vesicle or a single section the structural changes which occur in this or any other vesicular disease cannot be found out.

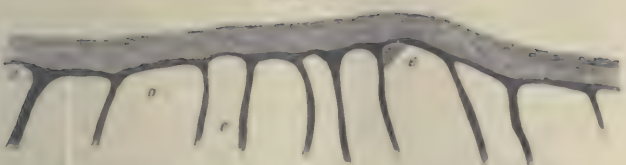
If more than one papilla is affected the appearance is changed, though only in some points. The liquid which comes from the different papillæ does not at first collect in the same place, but the liquid from each forms a separate vesicle, which afterwards unite and form a single larger vesicle. In figs. 3 and 4 such a condition is represented. The condition of all the cells except those between the different vesicles is similar to that already described as occurring when only a single papilla is affected. The cells lying between the different vesicles become flattened out into long fibres, and their nucleus gradually disappears with the lengthening out of the cell. In figs. 3 and 4 we have three vesicles separated by two bands composed of cells from the malpighian layer. As the vesicles arise from the papillæ these bands therefore must, and do correspond to the interpapillary portion of the stratum malpighi, and their size depends consequently upon the size of the vesicles and the resulting amount of pressure exerted upon these bands by the enclosed liquid. At first they are nearly as broad as the interpapillary space; but gradually become thinner and thinner, and the cells composing them more and more flattened and drawn out, until finally they are ruptured, and the vesicles which it had previously separated become united. In fig. 4 the vesicles b and c have become thus united. Therefore we are not justified in saying that a given vesicle is circumscribed because such bands are present, since they separate different vesicles from each other and not different parts of one vesicle. If the affected papillæ adjoin each other, as in figs. 3 and 4, and especially in fig. 3, then they may appear to the naked eye as forming a single vesicle. A very common occurrence in this disease however is the formation of bullæ from the confluence of two or more vesicles. In this case the vesicles are originally separated from each other by a greater or less distance according to the number of papillæ lying between them. When this occurs the vesicles spread, in the usual manner, and the liquid extending horizontally between the cell layers, the vesicles unite before the summit is ruptured. By this union of the effused liquid bullæ are formed, corresponding in size to the amount of liquid contained in the coalesced vesicles. The liquid passes horizontally either between the corneous and malpighian layer, or between the cells of the latter, and the intervening band is ruptured in the same manner and its cells become changed in the same way as when the vesicles arise from adjoining papillæ, as already described. This union of separated vesicles and consequent formation of bullæ is accidental, depending upon the amount of resistance offered to the escape of the liquid to the free surface by the structures forming its covering, and upon the distance between the separate vesicles. The disease must therefore be regarded clinically as a vesicular and not as a bullous eruption, though that is a matter of little importance, as the line of separation is so ill defined and merely arbitrary.

In the later stages of the disease, in which several adjoining papillæ are affected, the cell infiltration is greater comparatively than when a single papilla is affected. Instead of being restricted to the papillæ there is considerable round-cell infiltration along the course of the blood-vessels close to the mucous layer, between the papillæ. This infiltration of the upper part of the corium and into the malphigian layer is well seen in fig. 4. On account of the amount of cell infiltration into the latter their cells are no longer to be distinguished. This out-wandering of round cells accounts for the occasional opacity of the vesicles in the later stages, as they appear also in the liquid, as I have already written. No change whatever was to be found in the subcutaneous tissue beneath any of the vesicles. The sweat glands were found to be perfectly normal, and there was no distension whatever of their ducts with sweat. In one case the sweat duct was the principal structure separating two vesicles and delaying their union. Neither are the local changes of a catarrhal nature, as suggested by Mr. Hutchinson, as the cell infiltration consists only of round cells, and not of spindle-shaped or epithelial-like cells, as in catarrhal inflammations. As regards the nerves, they appeared quite normal. I studied carefully a considerable number of sections of nerve fibres, and I do not believe that they are changed at their periphery ; at least in such a manner as to be observable with the miscroscope. I believe the disease to be a neurosis, and dependent upon a change in the central nervous system not of the brain but of the spinal cord. Hence the little value of local applications in this affection.

We thus see that this disease is not one of the previously known vesicular or bullous diseases, but an affection entirely distinct in its clinical characters and in the changes which occur in the part affected.

In giving a name to this disease I have been guided by the wish not to add a new name to an already overburdened nomenclature, as is that of skin diseases. The term dysidrosis, as used by Dr. Fox, has been shown to be such an incorrect term, that it must be entirely discarded. As the disease so frequently attacks the feet as well as the hands, the term cheiro-pompholyx, as given to it by Mr. Hutchinson, cannot be retained. Recognizing, however, Mr. Hutchinson's claims and also the fact that the term pompholyx has not been employed by recent writers to designate any skin disease, the term pemphigus being employed instead of it, I have chosen to name it simply pompholyx. It is not intended by the use of this term to signify that the disease has any relation with pemphigus, indeed a study of its clinical characters and the mode of formation of the vesicles will show that it bears no closer relation to pemphigus than it does to herpes. I therefore use the term pompholyx to represent this disease, and think that it should no longer be synonymous with pemphigus, but that the latter should be used to denote pemphigus as understood by all modern writers, whilst the term pompholyx—a different word but also signifying a bleb—can be employed to designate this affection whose clinical history and

FIG. V.



a. Common wall. b. Upper Malpighian layer. c. Inter-cellular bands.
d. Process of corpus. e. Dip-cells in cuticle.

This section was taken from a bulla (vesicle) of an inch in diameter. The bulla was composed of 15 or 16 cuticles; a small second layer commenced the upper cuticles, and had an inferior number of epi-cells. Some are still on the apex at *d*. In removing the covering of the bulla, the layers separating the cuticles were the lowest part. Therefore in the removal together the bands extended from the layer of the upper Malpighian layer. All the cuticles were united between the cells, or dip-layer, and separated from the common base for one or more layers of cells of the true Malpighian. Two drawings, as well as the others shown that the liquid was easily collected between the cuticles and Malpighian layers, a circumstance which accounts for the subsequent bursting of the vesicles or bulla.

In this section the bulla containing the fluid were so distended that they appeared only as one layer. The cells at the upper layer, which formed the upper boundary of the vesicles, were also greatly flattened and very attenuated. The common base was four cells thick.

The portion of skin from which this section was taken was removed on July 24, 1873. On distant hiring occurred from the evening to take the section. The skin is from a bulla of that date preserved among the drawings.

nature I have here endeavored to describe. I hope the term will meet the approval of Mr. Hutchinson and dermatologists in general.

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CASES OF DISEASES OF THE SKIN DEPENDING ON NERVE LESIONS.

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A SHORT TIME since I enjoyed a peculiar opportunity for observing certain results on the skin and subjacent tissues of nerve lesion.

The cases were as follows: Some thirty patients were vaccinated within twenty-four hours by means of the hypodermic syringe. The point of the needle was inserted into the skin, and a drop of the fluid containing vaccine matter in solution was injected.

The injections were practised at various points in the different cases, all of them over the deltoid muscle of the left arm. The immediate effect in most cases was not very noticeable, though in a few there was much pain from the time of making the injection. But in all the cases without exception, certain unpleasant results followed, such as pain and swelling, heat and redness at the point where the virus had been inserted. This was accompanied by rigors, and fever, either slight or severe disturbance of the circulation, headache, and general *malaise*. In nearly all the cases an abscess appeared at the point of injury. But the phenomena to which I was more particularly to call attention were the following: In all the cases there was swelling of the affected member below the seat of the lesion, and in many if not most cases,—and before serious local disorder had occurred at the point where the injection had been made,—congested stripes appeared in the skin of the arm, extending downwards from the original seats of local disorder. These extended in the various cases, different distances down the arm, chiefly on its radial side, and were accompanied by swelling, more or less general, of the forearm, and in several cases led to circumscribed patches, as a rule irregularly oval, and varying from one to two or even more inches in length,—which were red, swollen, hot and tender to the touch, and the seat of a feeling of heat, burning, and pain.

The situation of these congested patches was chiefly on the radial side of the arm, and as a rule between the elbow and wrist joints. The elevation of the cutaneous surface, the heat, redness, etc., were quite striking when compared with the surrounding healthy

integument. Moreover, many of the elevated patches had an abundant crop of watery vesicles resembling herpes. These phenomena lasted from three or four days to two weeks, and then declined until they had wholly disappeared. It is particularly to the elevated congested patches, and the eruption which they sometimes presented, which I desire to call attention.

The original or first cause of the phenomena was undoubtedly the matter injected into and beneath the skin. Upon inquiry it was ascertained that it was composed of rather fresh vaccine matter from a healthy subject, which, it was shown, by introducing it in a different way, was active, and led to perfect results in the cases in which it was used. It was further learned that the virus had been carefully rubbed up in a small per cent of glycerine, and that a considerable quantity of rose water (*Aqua Rosæ*) had been used to dilute it, so that it would run through the needle of the syringe. The glycerine appeared to be fresh, but the rose water was found to have been not fresh, and to have been highly charged with bacteriæ or mycoderms of a kind not determined by actual observation and study. But whether the intense irritation set up was due to the mycoderms or to the glycerine, or as seemed to me more probable, to both together, could not be certainly determined. But one fact was clear, that after the irritation was kindled at the seat of injury the oval patches on the forearm were to be regarded as among its plain consequences.

Now, how can we explain in this case the production of the congested patches and the vesicular eruptions, occurring as they did at such a distance from the site of the original lesion causing them? It may be attempted in one of the following ways: By a lesion of certain long cutaneous nerves which pass downward over the region of the deltoid, and which are distributed to the integument of the forearm; the phenomena in question were produced either:

I. By means of a rapidly descending neuritis. The irritative process in this way was conveyed into that portion of the integument to which the affected nerve was distributed. The red lines which, in some of these cases, extended from the seat of original lesions downwards toward the forearm, would comport well with the notion of a descending neuritis.

Then, in those cases in which no such traces could be observed, it may have been true that the nerve trunk involved pursued a deeper course than did those which on account of their close relation to the skin led to a visible trace of congestion along their course. This view is essentially that of N. Friedreich, Tiesler, Feinberg, Kleme, and others, who have given much attention to the subject of neuritis in its various forms and results. I am inclined to receive this view as probably correct for certain cases, but practically untrue for others.

II. Then again, an attempt may be made to explain the phenomena in question by a reference to vaso-motor action.

This may occur in one of two ways, in such a case as the one

under consideration. It may be owing, either to the irritation of vaso-motor fibres (vaso dilators) contained in the nerve trunks which pass through the seat of morbid action. By this means an irritative influence is exerted on the peripheral vaso-motor apparatus belonging to the vascular area, which corresponds to the region of distribution of the affected nerve; in this way the congestion is produced. Or, the vaso-motor disturbance may be produced in a less direct way; irritation of the fibres of the sensory nerve, which is involved in the local disease produces an irritative impression in the nervous center to which the affected nerve leads, and the excitation thus of a limited portion of the sensory tract is transferred to the contiguous vaso motor spinal center, which, when excited, gives rise in a reflex way to the impulse passing along the outgoing vaso-motor nerves which have arisen from the vaso-motor tract of the cord and pass out toward the periphery, either in the plexuses which follow the vessels, or in the trunks of the spinal nerves; from this point onwards, the action being perfectly similar to that which was described as the result of direct instead of reflex excitation of the peripheral vaso-motor apparatus. But in either case, and as I believe in either way, may congestion be produced. But there is something more in this case than mere congestion, which seems to be all that can follow from lesions of the vaso-motor nerves, pure and simple. Congestions produced in this way have been known to endure for many months without the occurrence of demonstrable structural change in the parts which are their seat. There were certain *irritative* phenomena in these cases, as in so many other kinds of cutaneous disease. In the cases referred to, there is not only congestion, but manifestly signs of irritative action for which there are no known local causes, and which can hardly be accounted for by a reference to neuritis. How, then, is the local irritative action—the protracted tissue change—so often noted *pari passu* with the congestion, produced? By some means we must explain the circumscribed and apparently causeless irritative action.

III. It can only be accounted for on the supposition that certain of the cerebro-spinal nerves exert an influence over the nutrition of the body in such way as to increase or diminish, or even pervert or derange the same. The nerves through which this influence is probably most commonly exerted on the intimate nutrition of the tissues of the body are the sensory. In this case it is supposed that the sensory nerves which pass through the seat of disease, become the seat of irritation, and the impression thus produced acts in one or both of two ways.

Either, (*a*) the impressions produced in the nerve at the point of disease are conveyed toward the periphery where the nerve is distributed to the anatomical elements of the tissues, and excite and disturb the process of nutrition in them so as to bring to pass what has been called *irritation*,—or (*b*) the impressions produced are conveyed to the spinal cord, and an irritative state of the cell groups in which the related fibres terminate is produced,

which reacts through the sensory fibres on the tissues at the periphery in the manner described, so as to produce the irritation which runs along parallel to the congestion. As to the central location, in which the irritative action is set up, from which the influence emanates which disturbs the nutrition of the tissues in cases like the one under consideration, I believe the most common, not to say the only one, to be the groups of cells which are on the sensory root, and which constitute collectively the spinal ganglia. These, as I have pretty good reasons for believing, may become the sources of a disturbance propagated in a peripheral direction, along the sensory fibres, which may in this way trouble the nutrition of the area to which the affected nerve leads. This hypothesis requires, of course, that the sensory nerve fibres, which convey, as we know, impressions from the periphery to the center, shall also convey impressions the other way, that is, from the center to the periphery. And this I believe to be true. I have no reasonable doubt of it. It also requires that the nervous system shall exert what have been called *trophic* functions, about which there has been so much dispute. But I am fully convinced that it is charged with a certain control of nutrition for either its weal or woe.

But it is not possible for me to enter at length into a consideration of the grounds of these opinions. I expect to give full expression to my views on this subject and my reasons for them, during the present year. But that the local irritative action in the cases related, excited in circumscribed patches remote from the seat of original injury, was due to an influence of some kind exerted by the diseased irritated nerves, or propagated along them from the point at which they were diseased, I have not much if any doubt.

Many rather powerful and, taken altogether, convincing facts and arguments might be adduced in support of these views, but I cannot give them here. But passing from the local nutritive change, to the congestion, which accompanied it, we are led to inquire in what way it was produced? It may have been produced in the ways already alluded to, but it has seemed to me it may have been in another way.

In my present view, it may have been consecutive to the irritation or nutritive change. In other words, it arose in consequence of the local irritative action. The latter, it is supposed, was induced in a way already described, and hence involved in the common nutritive disturbance the local vaso-motor apparatuses, which are in immediate relation with the small muscular arteries and veins which permeate the tissues, and the result is a diminution in the tonic action of these diminutive peripheral vaso-motor mechanisms, and a consequent expansion of the blood vessels, or in other words, a *congestion*. Hence the congestion is chiefly limited by and proportioned to the extent and degree of irritative action.

But I shall not be able in this paper to do more than simply state the doctrines referred to, without discussing them. I may say that I have certain reasons for believing them to be something more than bare hypotheses.

Though the views I have enunciated are not novel, yet I have for years felt, as I have been teaching them, that they have a very wide range of application and are worthy of serious attention, especially on the part of dermatologists.

CASES OF HARE-LIP AND CLEFT PALATE IN SYPHILITIC CHILDREN.

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THE following cases of cleft palate with hare lip, occurring in children, one or both of whose parents were victims to syphilis, are reported with a brief history of each case.

CASE I. Mary S—, unmarried, was admitted to the Maternité Hospital of the College of Physicians and Surgeons to await confinement, which took place in due time and was in all respects natural. The infant at the time of birth was well nourished and looked to be vigorous. There was a deformity in its mouth consisting of a cleft in both hard and soft palate, and a hare lip of the left side. The hare-lip was of such a nature as to make it impossible for the child to nurse, and for the purpose of meeting this difficulty the usual operation was performed 10 days after birth. It would be well to state in this connection that, except there be some serious depravity of the patient's health, modern surgery approves an early attempt to remedy this deformity, for very obvious reasons.

One week after the operation a mucous patch attacked the line of the incision which enlarged rapidly to about the size of a five cent piece. The result was that, except at the labial border, the adhesions which had formed were broken up and the wound presented an ugly, ragged appearance. Somewhat later there appeared a profuse papular eruption over the greater part of the body, and later still desquamation of the hands began, notably of the palmar surfaces of the fingers. The little patient soon lost its ruddy appearance, wasted and looked puny and old.

Under specific and other tonic treatment its health improved. The medication consisted of the officinal "Hydrargyrum cum creta," which, though given in doses of 2 grains repeated every 3 hours, lasting over a considerable period of time, caused no bowel irritation, nor any but good effects. When dismissed from the hospital it was gaining flesh and strength as rapidly as could with reason be expected.

It was ascertained from the mother that during her pregnancy she suffered from intractable sore throat, a diffuse eruption, with

nothing definite as to sore on the genitals or elsewhere. There was good reason for believing that she had syphilis, but owing to the frequency of her exposures, no attempt was made to find out the source of her contagion. It was enough for our purpose to establish the fact, beyond cavil, that the child had syphilis, the appearance of which, I could hardly help from believing, was hastened by the depressing effect of the operation.

Case II. Mrs. S—, married 5 years ; has had during this period three pregnancies, the second of which terminated in a miscarriage. The first child was born with an imperforate anus, for the relief of which an operation was performed soon after birth by one of our Baltimore surgeons, with only partial success.

There remained in the lower rectum a dense stricture so close as to barely admit the point of a syringe, it having been necessary to rely upon enemata to secure the evacuation of the bowels. When four years of age she attended as an out-patient at my College clinic. The stricture was completely divided and continuous dilatation practised without the occurrence of re-contractions. During her attendance her little brother, aged 2 years, was presented for operation. He had hare-lip and cleft palate of the left side. In reply to inquiries, the mother stated that she had always been healthy and her general appearance coincided with this statement. The father admitted that he had had constitutional syphilis some time ago and had been under treatment for the same. When last seen by me, though not complaining of any distinct syphilitic symptoms, he seemed cachetic and in ill health. Both of the children were strong and healthy at the time of birth. The assumption of a syphilitic taint here merely depends upon the father's confession.

Cases III. and IV. Mrs. L— is a private patient of mine, with whose history I am quite familiar. She has been married three times. By her first husband, who was healthy, she had but one child, who has reached manhood in splendid health. From her second husband she contracted, what the physician called, "the seven years' pox." The tolerably clear statement which she makes of what she has suffered, the numerous scars on the different parts of her body, the history of periosteal and pericranial nodes and pains, together with the appearance of her mouth, confirm the Doctor's opinion as to her disease. After the nature and source of her malady were made out she separated from her husband without bearing, and before long was married to her third husband, who enjoys excellent health.

Since her last marriage she has had well-nigh one dozen pregnancies, all but three of which, and those the last, ended in abortions. Two of these three which came to full time, had cleft palates and hare-lips, and died very soon after birth with "*catarrh.*" It was during the next to the last pregnancy that my attention was called to her syphilitic condition, and I then instituted a vigorous anti-syphilitic management. Her last child is now living, and with the exception of some maculæ scattered here and there over the trunk, has been all right. As a precautionary measure, mercurial inunc-

tions are occasionally used with the hope of subduing any syphilitic tendencies that may be lurking in her system. Another case of hare-lip has occurred in my practice where there was reason for suspecting syphilis, but the case is inaccessible, and the history is not only too indefinite, but somewhat impertinent to admit of its being reported in this series.

At the time my attention was being called to these cases, my former colleague, Prof. Noel, reported to the Pathological Society two cases of cleft palate which he had seen in syphilitic children of different parentage. In neither of these cases was the duration of the disease in the parents stated. This would seem to be unimportant, however, inasmuch as, according to my list, the occurrence of the deformity in the offspring bore no relation to the stage of the disease reached in the parent. In case I, I feel quite sure that the syphilis was of recent origin, whilst in cases III. and IV. the mother had had syphilis for many years, long enough at least to develop tertiary symptoms.

In bringing these cases to the notice of the profession, I am not unmindful of the tendency, which is not altogether unreasonable, I must admit, to accredit syphilis with a very large share in the production of many disorders. One would think indeed that there are some, not a few, who believe it to be the "root of all evil." This dash of medical egotism cannot, I say, be deemed altogether unreasonable, especially if we incline to accept the startling figures which have been produced from time to time, showing the extent to which syphilis prevails in all of our communities. I am equally aware that the number of my cases is hardly more than enough to prove an interesting coincidence, certainly scarcely sufficient for me to be willing even to state that in these particular cases the disease in the parents was the direct cause of the defect in the children, still less to claim for it the merit of a general proposition. Yet I cannot think that it is altogether a coincidence, though not prepared exactly to define the *modus operandi*. There is abundant room for very rational speculation here, and if I were to argue the question from the standpoint of probabilities, I might write at length but still serve no useful end. The history and causation of all deformities make up a great secret, and have foiled the efforts of our best guessing-stars. Plausible and ingenious explanations have been offered, but the most, if not all, fail to satisfy. Plausibility and ingenuity are feeble foundations for a creed surely.

In regard to the deformity under consideration, we all know how heredity has been invoked, and its influence positively urged until collated facts disproved the connection. And again, with what persistency men and women, in and out of the profession, have turned to "maternal impressions" to solve the problem. We must believe, we can't help from believing, that both of these theories are not altogether groundless, and we cannot afford to ignore either of them. It is, therefore, not difficult to understand how a common belief in their influence obtains, even though this belief rests on an

unscientific basis. Persons not trained in close and careful reasoning, in cautious generalizations and inference, are apt to be hasty in coupling certain morbid states with conveniently supposed causes. And besides the *abundant comfort* which people seem to derive from tracing a trouble, be it disease or deformity, to some very indeterminate source, there is among many such an enormous love of the marvellous and mysterious. This whole subject of causation is involved in great perplexity. While our text-books and our individual experience abound in evidence of the very moderate progress made in the department of etiology, are we not often amazed at the glib disposition which some make of the cause of many a disease about which absolutely nothing is definitely known? With them very little suffices to establish cause and effect, and with them assertion equals argument and proof.

To this class of persons how conclusive the following case in point, taken from Geoffry St. Hilaire, seems to be: "A woman, 4½ months pregnant, has her attention called to a hare-lip case by her husband. During the last months of her pregnancy her imagination reproduces constantly this deformity, and she doubts not the child which she carries must be born with a like deformity. Some hours before her accouchement she announces in the most positive manner to the physician called to attend her that her child will present this vice of conformation, and her prediction is verified." With strange impetuosity those easily convinced forget to read the case of Nicati, in which "a woman, during four successive pregnancies had almost constantly under her eyes a child afflicted with this deformity of the mouth. She was convinced in each of these pregnancies that the child she was about to give birth to would be similarly misshapened, and still in not one were her fears realized.

Tiedmann discards the influence of both heredity and maternal impressions, and refers it to what he entitles the "inertia of vegetative progress" and the consequent imperfect formation of channels of blood-supply which depend upon it.

Vrolik and Nicati explain it, the cleft palate and ultimately the hair-lip, upon the ground of developmental interference, and offer to prove that the tongue, which is developed early in the fœtus, is pushed up and becomes an obstacle to the union of the maxillary bones if the buccal cavity is too straight and contracted to contain it. Their proof consists in the instances where fœtuses have been examined, and when they have found the tongues firmly wedged in the fissure.

In support of the latter position Geoffry St. Hilaire, jr., says that his father entertained the same opinion as to the cause of cleft palate.

For my own part, rejecting, so far as my own cases are concerned the influence both of heredity and maternal impressions, as neither apply, I am forced to the conclusion that in the six cases, well authenticated, in which syphilis and cleft palate were associated, there was more than a simple concurrence. With our knowledge of the dreadful havoc which this disease can and does produce,

especially in the mouth, is it logical to assume that it is not equally destructive to the nutrition or development of the embryo or fœtus? Does analogy permit us to award it the position of fell destroyer when it occurs in the adult, and that of a silent partner when it saturates the tissues of the individual in utero? How or why it is that the mouth should have been the part attacked in preference to some other, no valid explanation can be given. Might not the disproportionate vascularity of these parts, thereby securing an importation of a larger amount of the syphilitic virus to the structures, help to clear up the matter. As a matter of clinical interest I trust that this report may pave the way for a further investigation of the subject.

THE RELATIONS EXISTING BETWEEN ECZEMA AND PSORIASIS.*

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IN the present paper I desire to correct what appears to me to be an erroneous impression conveyed by most writers in regard to eczema and psoriasis. In reading articles on these diseases, I was forcibly impressed by the fact that the greater number of authors, although alluding to them as possessing some features in common, gave the impression that they were not so intimately associated with one another as I believe they are, and which the histories of cases I shall narrate, go far to prove.

We often meet with instances in which the characteristic points of diagnosis are so intimately blended, that it is very difficult to say, in a particular case, whether it is one of eczema simply, without any elements of psoriasis intermixed, or vice versa. Cases are not infrequent in which a person may have an eczema at one time, and a psoriasis at another period. Then there are persons, who are suffering from an eczema and psoriasis at the same time, and still others who may have a simple eczema, or an ordinary psoriasis, in which the characters of the eruption are so badly defined that it is not an easy matter to make a perfectly accurate diagnosis.

In the foregoing remarks, and those which follow, I do not wish it to be understood that I claim the two diseases to be essentially the same; I only desire to show that they are very closely allied to each other, and, in endeavoring to do so, I shall confine myself chiefly to the narration of a few cases, bearing upon the subject, which were observed by Dr. Bulkley and myself at his clinic.

The first patient is a girl nine years old, of strumous tendencies, of delicate build, with a pale countenance and flaxen hair. Her

* Read before the New York Dermatological Society, May 16, 1877.

mother says that she has had the present eruption for over a year; that it made its appearance about two or three weeks after vaccination, and that it continued uninterruptedly until we saw her. At the time she was first placed under treatment there was a characteristic eruption of psoriasis, occupying the favorite locations of that disease, viz: the extensor aspects of the upper and lower extremities, and body. On the elbows and knees, as well as on the left arm, at the seat of the vaccine scars, the patches were more numerous than elsewhere. The eruption consisted of a number of white, silvery, and imbricated scales, on red bases, with ill defined margins. These scales were pretty firmly adherent, but when removed left the peculiar bleeding surface characteristic of the disease. After remaining under treatment from January until the middle of the following April, she was discharged, there having been no appearance of eruption in three or four weeks.

The same patient came back to the Dispensary, in September following, and stated that her skin had been free from disease since seen by us until two weeks ago, when another eruption made its appearance. This time she was the subject of a squamous eczema, situated upon the *flexor* aspect of the arms and forearms, the other portions of the body being only slightly affected. The single patches of disease were larger than those seen in the previous eruption, more irregular, and freer from scales, although there was slight scaling. There was a considerable degree of thickening of the skin and evidences of scratching, as was shown by the excoriations.

This case goes to show that different causes, operating in the same subject, may, at one time, give rise to a psoriasis, while at another period an eczema will be produced. The first disease that the patient had was, without doubt, a psoriasis, as seen in the situation of the eruption, the character of the scales, and the bleeding and exposed surface left on removing them. That the second eruption was an eczema, there is no question, as shown by the amount of pruritus, the thickening of the skin, the flexor surfaces being attacked in preference to the extensors, and the absence of the silvery white appearance of the eruption. As to the cause of the patient having an eczema at one time, and a psoriasis at another, it is difficult to give any definite and sufficient reason. Perhaps the alteration in the type of the disease may have been induced by the different season of the year.

The next case is that of a patient in which psoriasis and eczema co-existed. A girl, sixteen years of age, and whose mother says that she has always enjoyed good health, but whose appearance indicates that she has been improperly nourished, has had an eruption on the hairy portion of the scalp ever since she was two years old. At that time, she had what appears to have been an impetiginous eczema, the head, according to her mother, being covered with a number of yellowish crusts, and the hair feeling as if glued together, so that it was with difficulty that it could be properly combed. This eruption disappeared, after lasting a few

months, to recur again when she was four years of age, disappearing and reappearing at intervals. Her hair has always been full of "dandriff."

Sometime during the summer of 1876, the present eruption made its appearance and has remained ever since. On the hairy portion of the scalp is a mixed eruption, partaking mainly of the character of an eczema, consisting of yellowish crusts, and the hair feeling as if it had been dipped in mucilage. Toward the edges of the hair the disease is psoriatic in appearance, being made up of small, circular, white, and scaly patches; no evidences of moisture are present in this situation; this condition also exists on the face and forehead. Above and behind the lobe of each ear is a moist eczematous eruption traversed with fissures, and having a margin which insensibly fades into the surrounding healthy tissues; the diseased skin in this situation is somewhat thickened. On the extensor surfaces of both arms, and especially at the points of the elbows, are several patches of disease, circular in form, and consisting of a number of silvery white scales, which, when scraped off, leave a bleeding and exposed surface such as is only seen in psoriasis. The same species of eruption exists on the back, thighs, and legs; the patches of disease, however, are more numerous on the thighs than the legs. There never has been any eruption on the knees, nor in the popliteal spaces. The margins of the diseased skin are not very well defined. At each elbow, on the flexor aspect, is a typical patch of moist and red eczema, about two inches by three in diameter; there are no scales in this situation and the skin is considerably thickened. About six months ago the finger nails began to be affected with psoriasis, and are now heat in and ribbed, presenting a concave, instead of a convex surface; the nails present, on their exterior, a number of minute depressions, which are circular in form, varying in size from a pin's point to a pin's head in diameter; the edges also are very irregular in outline. The patient complains of great itching of the skin, especially toward evening.

In the above case no one for a moment will doubt, from the description of the eruption, the fact of the co-existence of a typical eczema and psoriasis in the same person. The close relation existing between eczema and psoriasis is, to a certain extent, shown in the ill-defined margins of the eruption on that part of the body where the psoriasis exists. That a psoriasis does exist, on the extensor aspects of the body, is seen on an examination of the appearance of the scales, and on removing them, the fact of the peculiar exposed and bleeding surface remaining. That part of the eruption existing on the hairy portion of the scalp, behind the ears, and on the flexor aspect of the elbows, is an unmistakable eczema: on the head it is shown by the appearance of yellowish crusts and the glazy feeling imparted to the hair, while behind the ears and on the flexor aspect of the elbows, the skin is thickened and the surface bleeds readily on scratching, causing it to present a punctuate appearance not seen in psoriasis.

In connection with this case it may be interesting to quote Nayler,* who says that "psoriasis of the nails seldom exists alone, being more commonly connected with general or inveterate psoriasis, or else supervening upon eczema:" showing that he admits a certain relationship between eczema and psoriasis.

The following case will go toward showing that a person having a psoriasis may transmit an eruption to his children, which will take on the principal characters of an eczema.

J. R., aged 30, a man in good health, has had a psoriasis universalis for at least eight years. At the time of his first appearance for treatment, almost the entire body (flexor and extensor surfaces alike) was covered with a squamous eruption, consisting of silvery-white, micaceous and imbricated scales, firmly adherent to the surface beneath. On removing the scales a bleeding and exposed surface was brought into view. Those portions of the skin free from eruption were of a dusky red color. The disease existed on the head and face; extended downward, anteriorly and posteriorly, on the body; occupied both axillæ, and was also situated on both surfaces of the arms, forearms, thighs and legs; both the hands and feet were spared. On the lower extremities, the eruption was of a duskier red color than elsewhere on the body. There was considerable thickening of the skin, in all situations, but it was more marked on the flexor aspect of the elbows and in the popliteal spaces. The margins of diseased skin (where they existed) faded imperceptibly into the surrounding healthy tissues. The patient complained of intolerable itching, which was so excessive that it caused him considerable uneasiness, more especially when the surface of the skin became heated. On examining the patient's tongue a silvery-white patch presented itself on the dorsal surface, from which scales could readily be detached. Under treatment the eruption began to disappear in the centre of a diseased patch first, and on the upper extremities before the lower began to show any signs of improvement; it also faded from the flexor surfaces first, leaving a characteristic psoriasis on the extensors. He had two children under treatment at the same time; one, a girl one year old, affected with a dermatitis of the labia majora, approaching very nearly the character of an eczema rubrum; the other, a child four years of age, had an impetiginous eczema confined chiefly to the head and face.

The noteworthy features in this case are the existence of a psoriasis with the elements of eczema intermixed, and also the tendency to the transmission of the disease, shown by the children being subjects of an eruption somewhat similar in character. As to the disease having some of the elements of eczema, we have in proof of it: first, that the eruption was situated on the flexor, as well as the extensor, aspects of the body; second, the great amount of thickening of the skin; third, the gradual fading away of the eruption into the surrounding healthy tissues; and, last, the in-

* Nayler. Diseases of the Skin, 2d Edit. Lond., 1874, p. 34.

tense pruritus, although this latter symptom is often present in psoriasis and other diseases, but not to so great an extent as in this case.

The psoriatic nature of the eruption is shown by its occupying the extensor aspects of the body, the character of the scales, the fact of the patches of disease clearing up and healing in the centre first, also the disappearance of the eruption, under treatment, from the flexor surfaces previous to the extensors, leaving a characteristic psoriasis, and the coincident psoriasis? of the dorsal surface of the tongue. On this latter I do not insist, as I am well aware of the doubt in regard to the true nature of the so-called psoriasis buccalis.

A boy, seventeen years old, with strumous tendencies, pale countenance, flaxen hair, and slightly enlarged glands, has an eruption of psoriasis, situated on the extensor aspects of the body, consisting of whitish silvery scales, circular in form. While under treatment a papular eczema made its appearance on the face and head. The patient's mother is subject to rheumatism and he has nasal catarrh.

Another patient, a man forty years of age, has an eczema on the anterior surface of both legs and a few spots of psoriasis, of the guttate variety on the extensor aspects of the elbows. The eruption is a squamous one; it itches, and there is considerable thickening of the skin. The patient is also the subject of asthma, and, during his attendance at the dispensary, as his eruption improved, the attacks of asthma increased, this being probably caused by the bronchial mucous membrane becoming affected with eczema—a fact noticed by different authorities.*

The last case which I will cite is that of a married woman about twenty-one years old. She has a pretty general eruption of psoriasis, the peculiar features being that, although there are a number of silvery white scales on the dorsal surface of the hands, a number of fissures also exist in this situation, causing an appearance like that presented in the eczema rimosum of authors. The patient says that when she immerses her hands in water they become moist and itch greatly. In all other respects the case resembles, and is without doubt, one of psoriasis.

As further suggestions in regard to the more or less close relations existing between eczema and psoriasis I would recall that in a great number of cases of these affections, more so in the latter than in the former, the patients are subjects of rheumatism or gout, or else a tendency to these diseases exists. This fact has been recognized by several writers. Garrod† states that gout predisposes to and eczema and psoriasis. Murchison‡ also says that "in many cases these cutaneous diseases (referring to eczema and psoriasis) appear to arise from functional derangement of the liver, which often precedes gout, although neither the patient or any member of

* Allbutt on Internal Skin Diseases. Archives of Dermatology, Vol. iii., p. 1.
† Murchison. Functional Derangements of the Liver. New York, 1875, p. 140.
‡ Loc. cit., p. 140.

his family has ever suffered from this disease." Paget* believes that eczema and psoriasis are often due to a gouty state of the system, in the same manner that tophaceous deposits in the joints are the result of gout.

In both diseases, on examining the urine repeatedly, I have found that the specific gravity was greatly increased above the normal standard; was very acid, and loaded with lithic acid and lithates, showing a faulty assimilation of food and deficiency in the action of the excretory organs. This condition of the urine in these diseases has been observed by Nayler,† and others.‡ Bearing upon this point also is the state of the digestive system, which is found to be at fault in a majority of persons affected with either eczema or psoriasis. This is shown by the great amount of flatulence existing, the torpid condition of the bowels, and, as a result of these conditions, the frequency of headache, and coldness of the hands and feet.

Eczema is often called forth, or at least kept up, by the debilitated state of the system. As to psoriasis this cannot be so conclusively shown, although I believe that in certain cases a psoriasis may be induced by debility. In eczema the debilitated state of the system is demonstrated by the paleness of the countenance, flabbiness of the skin, by the enlarged glands in the neighborhood of the eruption, and, in the impetiginous forms of the disease, by the abundance of pus that is formed. In fact, in some cases of eczema, debility is the only appreciable cause that can be found to occasion the calling forth of the eruption. As to psoriasis being to any great extent dependent upon debility it is not so evident. We occasionally meet with cases in which the patient exhibits strumous tendencies, or there is a waxy appearance of skin, thick lips, flaxen hair and, in some cases, there is a considerable admixture of pus along with the scales of the disease. I have the notes of a case in which psoriasis made its appearance during pregnancy and was probably induced by the debility due to this state. Anderson § records cases somewhat similar, and one especially of a woman, in whom an eruption of psoriasis made its appearance when nursing her male children, but when she nursed her female children this was not the case.

Another feature, in both diseases, is that they are hereditary in nature. One often meets with patients in whom an eczema or psoriasis has been inherited from one of the parents. It even has been transmitted through two or three generations. As an instance of the hereditary nature of the diseases, we have the third case narrated, where the father was affected with psoriasis and two of his children had eczema.

* Paget. On Gouty Affections of the Skin. British Med. Journal, p. 737, June 5th, 1875.

† Nayler. Diseases of the Skin. 2d Edit. Lond., 1874, pp. 40 and 112.

‡ Bulkley. The Relation of the Urine to Diseases of the Skin. Archives of Dermatology, Vol. II., p. 1.

§ Anderson. On Psoriasis and Lepra. London, 1865, p. 14.

The constitutional nature of eczema and psoriasis is shown by the results of treatment. If they were simply local diseases one would expect that, under local treatment alone, the eruption would be cured. Such is not the fact, except in a very small number of cases, while under internal medication the eruption entirely disappears and the patient is generally restored to health.

Asthma and bronchitis are, in a certain proportion of cases, associated with eczema, and Gaskoin* refers to the former disease as occurring in psoriatic patients. I have seen persons having an eczema troubled with either asthma or bronchitis, but have not observed it in psoriasis, although some patients have chronic nasal catarrh.

The symmetrical development of the two eruptions is a noticeable feature in connection with the subject under consideration. If an eczema occupies the flexor aspect of one arm we generally expect to find it developed exactly in the same situation on the other arm; or, if in one popliteal space, it usually extends to be found on the other side. In reference to psoriasis, the same remark holds true as to similarity of situation.

Both diseases are chronic in their course, often lasting for several years, then again they are very apt to appear and disappear for an indefinite number of times, so that it becomes a difficult matter to pronounce a case absolutely cured.

As to treatment, in cases like those which I have narrated, and where the eruption partakes of the nature of eczema and psoriasis combined, our main reliance should be on alkalies administered internally. Local remedies are of service as palliatives and adjuvants, but the cases are few in which a cure is effected by local measures only.

My reasons then, in brief, for believing that eczema and psoriasis are very intimately related to each other, are:

First, we not unfrequently meet with cases in which the two diseases co-exist.

Second, a person may have an eczema at one time and be subject to psoriasis at another period.

Third, the tendency towards gout and rheumatism which exists in eczematous and psoriatic patients.

Fourth, the derangements to which the urine is subject in both diseases.

Fifth, the debilitated state of the health sometimes seen.

Sixth, the hereditary natures of the two diseases.

Seventh, their constitutional nature.

Eighth, their symmetrical development.

Ninth, their proneness to recur and their chronicity.

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* Gaskoin. On the Psoriasis or Lepra. Lond., 1876, p. 53.

THE PATHOLOGY OF HERPES ZOSTER, CLINICALLY CONSIDERED.

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SINCE the publication of Von Bärensprung's classical memoir on the "Girdle-disease," the opinion has been generally held by dermatologists that herpes zoster is essentially a neuropathy; in other words, that the morbid anatomy of the affection explains its pathology. Apparently fully accepting this view, Dr. L. D. Bulkley * in his recently published classification of Skin Diseases, places herpes zoster among the neuroses, and justifies his action in these words: "***Its true nervous origin is now so incontestably demonstrated that if we wish to really base our classification on pathological facts, this disease should form the centre around which we may group others whose clinical features are wholly neurotic, but whose nerve origin is at present less clearly demonstrated."

Before we commit ourselves to this conclusion, and thus upset and destroy a part of the grand generalization presented in the classification of Hebra, it would be well, I think, to again examine the question from the clinical stand-point, using "pathological facts" only in the way they will fit, and not endeavor to force them into positions where they do not belong.

Believing, then, that the affection under consideration should, for the present, retain its position among the *acute exudative dermatoses*, and agreeing in the main with Kaposi, † I claim for herpes zoster a relationship or analogy to the specific eruptive fevers (rötheln, acrodynia), or neuroses (pertussis). The grounds upon which I believe myself justified in so considering Zoster, are the following facts in its clinical history.

1. The strictly self-limited character of the disease, and its tendency to spontaneous recovery after a slightly varying duration.

2 The constant occurrence of more or less well-marked prodromic symptoms.

3. The character which it possesses with the other specific diseases, of occurring but once (generally) in a lifetime.

4. The uselessness of attempts to "cut short" the disease by therapeutic measures; and,

5. The well-attested quasi-epidemic character of its prevalence at times.

In regard to the first three of the points here mentioned, it would be superfluous to say anything to the readers of this journal; they are facts in the clinical history of herpes zoster which are universally recognized. As far as the fourth and fifth points are

* Archives of Dermatology, III., 3, April, 1877, p. 200.

† Hebra and Kaposi; Hautkrankheiten; 2 Band; Stuttgart; 1876, p. 541.

concerned, I shall briefly put forward some of the evidence which may be urged in their support.

Hebra * condemns all interference with the natural course of the affection, because other than tentative treatment is more likely to prolong than to abbreviate its duration. Tilbury Fox, who certainly is not skeptical in regard to the treatment of skin diseases generally, says:† "The great thing is to avoid too much meddling." The latest American authority on dermatology ‡ expresses himself as follows: "It will be borne in mind that the affection runs an acute course, terminating in spontaneous recovery. * * * Internal medication has not heretofore proved of much avail in influencing the course of the eruption." Sir Thomas Watson, who is certainly no mean therapeutist, asserts that very little can be done, or is requisite, in the way of treatment. "Our main business is to look on, and endeavor to set right whatever function may be manifestly wrong."§ Dr. L. D. Buckley,‖ gives phosphide of zinc with nux-vomica, to control the pain, not to "abort" the disease. In a more recent publication,¶ the same author thinks, however, that he has seen this remedy arrest the cutaneous manifestations as well as the pain. In the absence of more extensive experience, this effect may reasonably still be questioned.

With regard to the apparently epidemic character of its prevalence the testimony is sufficiently, if not equally strong. Thus Neligan ** says that "in the summer and autumn of some years it would appear to be epidemic among children;" and Tilbury Fox,†† "It is most common in the young, of about equal frequency in the two sexes. It seems on some rare occasions to be almost epidemic." In a recent discussion before the *Baltimore Clinical Society*, Prof. Sam'l. C. Chew, in introducing the subject of herpes zoster, said he had lately been consulted in quite a number of cases of this affection, and found upon inquiry that a number of his professional brethren had a similar experience; in fact, continued Prof. Chew, it seemed as if we were then "in a wave of Zoster." I am informed by a gentleman who has practised medicine many years in the country, that, with one exception, all the cases of Zoster he had ever seen—six or seven—occurred within three or four months of each other.

The evidence here presented will, I trust, show that the essential nature of herpes zoster must be sought beyond the structural alteration in the nerves or spinal ganglia; that, in fact, the local alterations in the nervous and cutaneous systems are only results of a previous blood infection. Why it

* Hebra and Kaposi, Hautkrankheiten, 1. Bd. 2 Aufl. Erlangen, 1874, p. 325.

† Skin Diseases, New York, 1871, page 117.

‡ A pract. treatise on Dis. of the Skin, by Louis A. Duhring, M. D., Phila. 1877, p. 222.

§ Lectures on the Practice of Physic, Phil., 1872, Vol. II., p. 944.

‖ Archives of Dermatology, II., 2, Jan. 1876, p. 158.

¶ Am. Journ. Med. Sci., July, 1879.

** Dis. of the Skin. Phil., 1852, p. 88.

†† Loc. cit., p. 113.

is, that Zoster occurs so frequently as the result of trauma, or where epidemic influence cannot be traced, I am unable to say; but this difficulty is certainly no greater than that of accounting for the so-called "sporadic" cases of cerebro-spinal meningitis or whooping cough.

A skin disease of strictly local origin—like the majority of cases of eczema, for example—does not tend like Zoster to such rapid recovery; the seat of an old eczema seems to be more vulnerable with each successive recurrence of the disease; such is not the case with herpes. If we regard Zoster as a neurosis, it must be looked upon as unique, for neuralgias, epilepsy, &c., are proverbially the bug-bears of medicine from their obstinate resistance to treatment, and their frequent recurrence; finally, the prodromata of neuroses are in the majority of instances, indistinct or altogether absent.

The only serious objection to the views here expressed that has suggested itself to my mind, is the generally unilateral character assumed by herpes zoster; but we find an approach to the analogy in cynanche parotidea which rarely *begins* bilaterally, although it usually becomes so in a few days.

Subjective symptoms have not been referred to, because they prove nothing either way. The neuralgia which sometimes persists long after the eruption has disappeared, is not to be regarded as part of the disease, but as a sequela; bearing the same relation to herpes zoster that the perversions of motion (paralysis) do, which not rarely follow diphtheria or scarlet fever.

NOTES ON THE LOCAL TREATMENT OF CERTAIN DISEASES OF THE SKIN.*

BY L. DUNCAN BULKLEY, A. M., M. D.

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X. *Erythema.*—The local treatment of erythema should always be of the most soothing character, remembering well the acutely congestive character of all forms of the disease; and many of the remarks previously made in reference to acute eczema, especially in children, are especially applicable to erythema. Ointments are seldom called for, indeed grease to the skin not unfrequently serves

* These "Notes" are intended to report, for the use of the general practitioner, the local measures in common use by the writer in the treatment of diseases of the skin, and which may be safely employed: it is not intended that they shall be exhaustive, nor that these measures are recommended to the exclusion of constitutional treatment: the formulæ are not claimed as original, although some of them may be. These "notes" are continued from pages 212 and 307 of Vol. II., and pages 24 and 127 of Vol. III.

as an irritant; and relief is obtained from powders or lotions. Powdered starch is one of the best applications. Other powders have been already mentioned under eczema. Of lotions, I think the most benefit is derived from such as on drying leave a film of powder over the surface, and either of the following will be found grateful to most erythematous skins: ℞ Pulv. calamin. prep. ʒss.—ʒi.; zinci oxidi, ʒi.—ʒii.; glycerini, ʒii—ʒiv.; aquæ rosæ, ʒiv., M. ℞ Bismuth. sub nitrat., ʒi.—ʒii.; acidi hydrocyan. dil. ʒi.; Aquæ Aurant. flor. ʒiv., M.; the latter to be used only when the skin is entirely unbroken; sometimes a weak carbolic acid lotion (grs. ii.—v. ad. ℥i.) or acetate of lead (grs. ii.—v. ad. ℥i.) with or without opium, or a simple evaporating lotion of alcohol and water, is really the best local application that can be made, but generally little local treatment is required unless the burning is severe.

In erythema nodosum there is sometimes very considerable pain in the nodule-like swellings, and when on the lower legs they will be relieved by elevating the limbs and keeping hot fomentations upon them, at times cold water is more acceptable; there is more danger of using too much than too little locally in this as in all forms of erythema; it is well to remember that the swellings even of erythema nodosum rarely if ever end in suppuration.

XI. *Favus.*—Fortunately this is a rare disease in this country, for it is generally a very obstinate one as it is ordinarily treated by the general practitioner. When the disease occurs on the body or parts other than the hairy scalp, it is comparatively easy of removal and generally yields very rapidly to a parasiticide, as dilute citrine ointment (1:3) or sulphurous acid of full strength. On the scalp, when firmly rooted, the disease requires the utmost patience on the part of physician and patient, and the greatest persistence in the judicious use of local applications which are measurably severe.

First, epilation, or the extraction of the hairs is an absolute necessity in cases which have lasted long, that is, months or years, for it is only after the removal of the hair that the agent destined to destroy the parasite can reach to its principal abode, the hair follicle. Some care is necessary in extracting the hairs not to break them off, they should be drawn out carefully in the direction of their long axis; one patch or portion of the disease should be *thoroughly* epilated at a sitting, all the hairs being removed, any one portion may require to be epilated a number of times during the course of treatment, which at the best may last from three to six months, possibly much longer. The hairs are to be extracted as long as they are diseased, and the microscope should be employed from time to time to learn their condition.

Directly after epilation the operator is to rub in a wash of bichloride of mercury (gr. i.—iii. ad. ʒi.), and the whole of the diseased surfaces are to be kept smeared night and day with an ointment, as the citrine diluted (1:2 or 3) or turpeth mineral (grs. xxx. ad. ʒi.), or it is to be kept well rubbed with the pure oil of cade. Of course if crusts exist at any time they are to be removed mechanically, softening them with oil first, if necessary.

XII. *Fissures.*—No more annoying cases are presented for treatment than are some of those which have as the main feature one or more fissures of the skin. Those referred to are especially seen about the nose, mouth, nipple and anus, as also on the ends of the fingers. Very often these are plainly but a part of eczema and yield to proper measures for this, but often they resist treatment most annoyingly. The most effective treatment I have found to be that of touching the base of the raw surface well with a stick of pure nitrate of silver, Squibb's points are the best, and then covering them with some protective dressing until the eschar drops off, when the process is to be repeated, if necessary. For the mouth and nipple the compound tincture of benzoin answers the best, and by means of this cracks of the nipple may be healed while the child still nurses. Superficial fissures in the anus very frequently yield to the same treatment, except that after the application of the nitrate of silver an ointment of equal parts of ung. hydrarg. and ung. belladon. is to be kept applied. Deeper fissures, of course, require surgical interference, rupturing the sphincter, etc.

The ends of the fingers sometimes crack and split in a very annoying manner, and from no appreciable cause. The best measure which I have found for this is to soak them in very hot water every night, then to make pretty severe friction with the compound tincture of green soap (℞ Saponis viridis, olei cadini, alcohol aa ℥i. M) or with a wash of caustic potash (grs. v.—xx. ad ℥i.), and to keep on a subsequent continuous application (or certainly at night) of the unguentum diachyli, for which the formula has been already given (page 126, Jan., 1877). Nitrate of silver is often of service in all kinds of fissures, which may also be subsequently painted with collodion or the liquor gutta perchæ of the U. S. P.

XIII. *Herpes.*—The little that is to be said in regard to the local treatment of the acute vesicular disease herpes is included under the one word protection, and the avoidance of irritation. For herpes zoster I almost invariably order the surface to be thoroughly dusted with finely-powdered starch, and, if it is at all possible, a linen or muslin band, also well dusted with starch, is to be tightly applied over the affected surface and sewed around the body or limb, it being left in position until the vesicles dry up, in something like a week. Collodion, made flexible with a few drops of castor-oil, is also an excellent dressing, and if there is much pain a little morphine may be added to it. Plasters of all kinds and poultices should be sedulously avoided in all the forms of herpes, as there is always more or less tendency to the formation of minute sloughs, and these may run together, causing sometimes an ugly sore if improperly managed. The calamine or bismuth washes mentioned under erythema may also sometimes be of service in herpes.

XIV. *Hyperidrosis.*—The treatment of this annoying excessive secretion of sweat, especially from the palms and soles, has been already given under the heading "bromidrosis" or offensive sweating (vol. ii., p. 310), and need not be here repeated.

XV. *Ichthyosis.*—The local treatment of this disease is very im-

portant, because upon it depends very greatly the comfort and well-being of those whom internal measures can hold out little or no prospect of benefiting. Very much relief may be obtained by local measures, all of which have for their object the macerating of the external layers of the epidermis and keeping them soft and pliable; to this end frequent bathing should be resorted to, the ichthyotic patient may take a warm bath several times a week, or even in some instances daily, with benefit. The efficacy of the bath is increased by the addition of some of the alkalies, as mentioned (page 123, vol. iii.) in the treatment of eczema. The medicated bath may be given once or twice a week, and a simple warm bath on the other nights. Vapor baths are also of great service, and may be taken several times a week.

But simple, or vapor, or medicated baths will usually leave the skin too dry, and it will be advisable, as a rule, to apply some emollient or fatty matter after them; for this purpose the glycerite of starch has served me very well, also cosmoline, the whole body being lightly but thoroughly anointed with it, the former (the starch ointment) being applied while the body is still wet. Any of the oils answer well for the inunction, and in recent cases, especially in young patients, cod liver oil should be freely used to the surface. If glycerine agrees with the skin it may be used, diluted from three to six times, with water.

XVI. *Impetigo.*—Impetigo requires but little local treatment except in the way of protection, and there is far more danger of error of over treating it locally than of doing too little. But the inflamed pustules require to be shielded from irritation, and the best application is an ointment of oxide of zinc in rose ointment (℥ss. ad ℥i.) or bismuth sub-nitrat., in the same proportions. The parts should not be washed, but allowed to dry beneath the crust formed by the exudation and the ointment; it is often better even to spread the ointment on lint and lay it on, or to apply it with a camel's hair brush, to avoid unnecessary stimulation.

XVII. *Intertrigo.*—The local measures described under acute erythematous eczema and in erythema are those suitable to this affection. In fleshy persons as also in infants it is sometimes difficult to remove the tendency to chafing of adjacent parts, the secretion from the sweat glands causing every powder which is applied to become a paste; when this is washed off too frequently and severely still greater irritation is caused. The remedy in this case is to interpose dry linen, dusted with the powder and held neatly in position, this to be changed as frequently as necessary, that is, before it becomes saturated, perhaps three or four times a day; the old measure of burning or scorching the cloth first is a good one, and I have thought that it assisted the cure. Something may be accomplished after the acute stage is passed, by using washes of tannin to harden the skin; ointments are very frequently ill borne in intertrigo.

XVII. *Lichen.*—The different varieties of lichen demand very different local treatment; the acute form is aggravated by anything

but the most soothing measures, while in the chronic variety of the lichen simplex, or lichen agrius, very powerful stimulants are not only well borne but are necessary to relieve the intolerable itching. The washes advised under acute eczema and erythema are all suitable to acute lichen, as are also mild ointments as the oxide of zinc or bismuth, half a drachm or a drachm of either to the ounce.

Chronic lichen simplex, which possesses many points of difference from papular eczema, which cannot now be referred to, frequently yields very well to frictions of the compound tincture of green soap (℞ Olei cadini, saponis viridis, alcohol aa. ℥i. M.) with the subsequent application of a mildly stimulating ointment, as zinc, diluted citrine, diluted white precipitate, etc.; occasionally the itching is so severe that the continual application of a tar remedy is necessary, when the spots may be painted several times daily with a tincture of tar (℞ Olei rusci ℥i.; alcohol, ℥i.—℥ii. M. et filtra), or tar ointment of half or full strength.

Lichen planus, after its acute development, will generally stand some stimulation, although I seldom advise any local measures in any stage of it. Lichen pilaris requires frequent bathing and the free employment of such a soap as the sapo viridis of the Germans, a strong potash soap; the baths may be rendered alkaline in the manner previously described, and if the skin is too dry after them, as is usually the case, any mild inunction serves to relieve the tension of the skin, as cosmoline or any of the oils, or glycerine.

Lichen scrofulosus, a disease seldom seen in this country, is best removed by cod-liver oil externally as well as internally, and it should be very thoroughly rubbed into the eruption once or twice a day, and the skin as far as possible kept soaked in it.

(TO BE CONTINUED.)

Clinical Reports.

I.—*Four cases of Chronic Eczema treated by Nerve Tonics and Electricity.* By W. H. Fitch, M.D., *Rockford, Ill.*

Some time since Dr. Bulkley of New York,* in an able article, drew the attention of the profession to the influence of the nervous system in many forms of skin diseases. In this he has done his brethren a valuable service, enabling them now to heal many cases that had proved obstinate to the German plan of treatment with ointments and lotions, and the English method of arsenic and colchicum. I do not care at this time to take the space to consider the pathology, causes or other kinds of treatment of eczema, but will simply detail four cases in brief to illustrate, so far as they will, the "nerve tonic treatment" of chronic eczema.

Case I. In my drives about the city I had noticed almost daily Miss A. D., aged 13, to be a sufferer from some affection of the face, which I took to be eczema. Finally in August, 1873, while passing the house I saw her swinging on the gate, and I reined up my horse by the sidewalk and asked her to let me look at her. While I was talking to her, her mother came out, introduced herself, and said she had thought of bringing the child to me (as I was the last doctor that had come to town), but considered it of little use, as most of the other physicians had treated her for the last eight years, with but temporary or no benefit, and they had nearly kept themselves poor by paying for medicines and treatment. I told her I thought the case was curable, and I was so confident, that I promised to pay for the medicines and charge nothing for treatment if I did not succeed. With this proposition I entered the house to examine the patient. I learned that she had suffered from the present disease since she was four years old; that during this time she had had several attacks of acute and subacute rheumatism and asthma; that when she was suffering from asthma or rheumatism the eczema was better, and vice versa, as is often the case in these affections. The entire cutaneous surface was involved in this case. The neck, face, scalp, forearms and legs having been recently newly invaded,

* Archives of Electrology and Neurology, Nov. 1874 and May 1875.

presented a weeping, oozing, raw, red surface, while other parts were covered with scales and crusts, and the remaining surface was dry and rough. She was slender, lean and nervous from her constant suffering and loss of sleep. The mother and sister had a rough skin, but had never been annoyed by any outbreak.

The patient had been treated with arsenic several times, and all the ordinary kind of ointments. I ordered her cod-liver oil with phosphate of lime and camphorated cosmoline externally.

Sept. 1st. Patient has gained somewhat in flesh, but there is no particular improvement in the eczema.

Ordered oxide of zinc, nux vomica, and iron, in pill form, and dilute phosphoric acid internally.

Sept. 24. Patient much improved; face and neck nearly well; itching much diminished; treatment continued.

Oct. 15. No improvement since last date, ordered phosphide of zinc, camphor, nux vomica, and cincho-quinine in pill; also phosphoric acid and hypophosphite of soda; directed to come to the office every other day for electricity.

Oct. 30. Patient entirely well. Has had galvanism applied every other day since Oct. 15th, at one visit it being applied to the sympathetic nerves, the next to the diseased surface.

At first I only used two cells, but gradually increased to 12 of Stohrer's battery.

At this time she began going to school for the first time in her life. She remained free from eczema, rheumatism, and bronchitis up to the last of 1876, when I lost sight of her.

Case II. Mr. M. L., aged sixty-five, presented himself June 4th, 1875, with eczema universalis chronicus. He had suffered intensely for several years. Had swallowed six hundred bottles of regular and irregular medicine, and applied some hundreds of salves and lotions. His entire skin was the most pigmented from constant scratching that I have yet seen. The skin was thick, dry and leathery, and in many places would crack, if pinched.

He was able to sleep but half an hour at a time, and generally rose several times during the night to bathe himself with cold water, carbolic acid, hydrocyanic acid, or other of the many lotions he had used.

He suffered most about the scrotum and face, which parts felt as if ten thousand insects were crawling over them. He was an intelligent man, and had kept quite close observations of his medicines and their effects. Had taken arsenic for a year at a time until its specific effects were produced, with no benefit. Received most benefit from alkalies internally and cold cream externally. Had paid most scrupulous attention to cleanliness.

I began treatment by the administration of the following prescription: ℞ Zinci phosphidi 15 gr.; ext. nucis vom., 20 gr.; pulv. camphor., 60 gr.; ferri redacti, 60 gr.; cinchonidia sulph., 60 gr.; m. et divide in pill no. 60. Take one after each meal. Also a tumbler of Waukesha water three times a day. At the same time I began the use of galvanism to the sympathetic and

parts affected. I first began with two cells, which he bore with difficulty. The next day after the application he reported that he had slept two hours at a time, which he had not done for years. During the treatment I gradually increased the cells to 32. The only external application was an ointment of chloral and camphor to allay itching. I need only say that this treatment was pursued more or less for three months, when he was discharged cured, and has so remained.

Case III. Rev. M. H., of this city, had suffered for years and gone through much the same experience as case II.

I administered the same pills and gave acetate of potassa in place of Waukesha water; applied galvanism once or twice a week—sometimes not for two weeks. The case was cured in about three months, except the face, which proved obstinate to everything. There is scarcely any trace of the eczema on the face, but the formication and itching occasionally light up.

Case IV. Mr. L. R., aged sixty, school teacher by profession; had been afflicted with eczema for six years, especially on the face arms, scrotum, penis, perineum and legs. Had given up teaching on account of the malady and gone to Chicago for treatment and change of work. After two years of unsuccessful treatment, during which time he says various treatments were tried, he came to consult me at the solicitations of his friends. I ordered him phosphorus, nux vomica, hypophosphites, phosphoric acid and laxatives. I also applied galvanism every other day for five weeks, when he left the city entirely well and has since so remained.

I might extend this list to thirty or more, but have already surpassed my intended limits. These four are sufficient to indicate the line of treatment I have found most beneficial in cases of long standing eczema, while recent cases generally give but little annoyance to any of us. I should be glad to hear more of the details of treatment of others in these cases, in this journal.

II.—*Clinical Conversations on Diseases of the Skin.** By the Editor. *Reported by Robert Campbell, M D., Clinical Assistant.*

Case I. *Eczema rubrum of left leg, with furuncles elsewhere.* This patient before you exhibits an affection which, if I mistake not, will some day give some one if not all of you considerable trouble, and which is one well worthy of your careful attention; for, unless managed just rightly, these cases are very intractable. This man is about fifty years old and of apparent good health, a printer by occupation, but he says he has not been able to work for more than a month on account of this leg; dermatology is sometimes slightingly spoken of because so few comparatively of its cases are such as to endanger life, or even seriously to prevent the pa-

* Cases shown and remarks made to private classes at the Demilt Dispensary New York.

tient from working; but here you see a case where skill may be of the utmost value, for this man has already been under treatment for some weeks with no improvement, but with a steady increase of his trouble. Let me advise you to pay a great deal of attention to the study of eczema of the legs, for such cases as the present are of constant occurrence in every private as well as public practice.

Our patient tells us that, with the exception of boils, which have come and gone for several years, he has had no eruption on the skin until September, 1876, when a small itchy papule appeared on the left ankle. This he scratched, it became somewhat moist, and the area of disease increased to a patch two or three inches in diameter. He then applied some ointment given him by a druggist, and it disappeared, somewhere about December first. About May first of this year the lesion began in another locality, on the lower third of the leg, and from a comparatively little spot has spread in these seven weeks upward and downward until now you see the entire dorsal surface of the foot, the ankle and the whole leg nearly to the knee are covered completely with a red, moist, or scaly surface, which itches when it gets dry and burns when it becomes moist, and altogether keeps him from earning anything by work; the right leg is free from disease.

Now there are several points in regard to eczema of the legs to which I wish to direct your especial attention. First, the disease is seen far more commonly in those who are over 30 or 40 years of age and who have worked hard: it is not an affection of idlers: it is often one of the first signs of a breaking down of the vital powers which will be presented to the physician. This man says he was always previously strong and well. It is therefore a disease which demands rest of the part or also rest of the body, and mind, if it have been taxed.

Second: You will most commonly find it in those who are of constipated habit; this man says that his bowels act only every few days, and his tongue is coated; and I do not think it possible to remove entirely the cutaneous disease on the legs unless you remedy the inactive bowel and the sluggish portal circulation which is associated therewith; therefore never neglect this. Together with the constipation you will very commonly find deficient or faulty urinary excretion, which will require to be remedied, to give permanent benefit to the leg.

You will generally find that these patients wash the parts very freely, because it gives relief from the itching and in order to remove what appears to be dirt; and you will find many physicians who counsel washing the part with soap and water once or twice daily. This man has been doing this with castile soap, and says that it causes it to sting and smart terribly. This is not my practice. I think it irrational to wash a surface devoid of epithelium, and my constant injunction, you hear, is, "do not wash the part until I tell you to," and you see the result.

I think the greatest errors are made in eczema of the legs in the way of over stimulation; thus you have repeatedly seen patients

here who had strong mercurial or tar or resin ointments on just such legs, which caused a constant exudation and much pain. There are certain principles of therapeutics which it is well to bear in mind when about to prescribe for such a leg as this; such are, that continued stimulation results in inflammation, whereas intermittent stimulation, other elements being regulated, results in absorption and health. I question if a purely soothing treatment would have any effect on such an eruption as this one; there is already too much thickening of tissue, and the mechanical obstacle of the retarded circulation incident to the location is too great to be overcome by wholly mild measures.

We will therefore relieve the bowels by our pill of blue mass, colocynth and quinæ, and order that he rest from walking and keep the leg elevated above the head: this is accomplished at night as well, by elevating the foot of the entire bedstead with two or three bricks under each leg. Inasmuch as he is incapacitated from work and can bear pretty severe treatment, we will sponge the leg rubbed with the "*liquor picis alkalinus*" full strength, once daily, or every other day if the effect is too severe. Some friction must be made, with a piece of flannel. If the pain and burning is severe, he may keep cold water dressing on for a while, and afterwards apply an ointment made at home of equal parts of mutton tallow and cod-liver oil, melted together; if the pain is not very great, the cloths spread with the ointment may be laid on at once.

The idea of this treatment is the powerful stimulation of the parts for a few moments, together with the removal at effete matter; exudation then occurs, reaction sets in, the vessels contract, the ultimate supply of blood is lessened, and the tissues recover their tone. If this stimulation is too great an occasional friction with Hebra's tincture, of green soap, oil of cade and alcohol, of each equal parts, may be used; if *zinc* or other ointment is used to such a leg it should be comparatively weak and unirritating. The same stimulation may be accomplished by the green soap alone, or by solutions of caustic potash from ten to thirty grains to the ounce.

But as before reiterated, I do not regard this state of the skin as a wholly local affair: when it first appeared it came on the ankle, and yielded to a remedy which restored tone to the parts, the second time, soon after, it appears elsewhere on the leg, and spreads far more than on the first occasion, and has failed to yield to local treatment: moreover, he says that for several years he has been having boils off and on. You will therefore best help these cases by studying the patient's health and prescribing accordingly; when this acute disease passes by he should by all means wear an elastic stocking for months or years to prevent its recurrence.

Case II. *Erythema papulatum.* The eruption on this girl's hand looks so much like syphilis that it will be well to examine it carefully, because the error would be very great if it were treated as such.

She is, as you see, an apparently healthy and well-developed girl of 18 years, a maker of artificial flowers. She says she never

had any eruption on the skin until last year, about this same season, when she was similarly affected for a few weeks. The present eruption made its appearance about two weeks ago, and has continued to increase and spread up to the present time. It now occupies the lower fourth of both arms, the wrists, backs of hands, and to a slight degree the dorsal surfaces of the feet, affecting also moderately the face. It consists of red papules, mostly rather flat, some as small as a pin's head up to patches of even ½ inch diameter. You observe that the redness of them disappears when I press with my finger and quickly remove it, but returns again almost instantaneously; moreover, there is a slight staining left even when the blood is thus forced out: you also perceive a small amount of elevation both on passing the finger lightly over the part and when you press upon the lesions; for this reason it is called erythema papulatum, and is placed by Hebra among the exudations, because there is a small amount of effusion into the skin.

When I first looked at the eruption and learned the occupation of the girl, the thought arose that it was due to some local cause, as some poison used in making artificial flowers; but she tells us that there are some fifty other girls at the same work and they are not affected, except perhaps a couple of others have some trouble, which may or may not be the same; also that she has worked at the same occupation for two years, and is using no different dyes or materials from those she has long worked with. Further investigation, however, reveals the eruption in its same peculiar characters upon the face and on the dorsum of the foot, showing the true nature of the disease, which is well recognized in dermatology.

The eruption is mainly self-limited, although its course may sometimes be considerably prolonged, and really does not require much treatment. It is important, however, not to do the wrong thing, and especially would it be a grievous mistake to suppose the eruption a manifestation of syphilis. The patient complains of headache, and says the eyes feel sore: we will order her the laxative iron and magnesia mixture which we so often prescribe as Startin's mixture: locally nothing is required.

Some one suggests if this could not be urticaria, some of the patches resembling somewhat the wheals of that disease, and she said that it itched and burned somewhat. The differential diagnosis is made from the smaller character of most of the spots, the location on the hands and wrists and backs of the feet (urticaria would never be thus localized), and very largely from the permanent nature of the lesions, those of urticaria being very transient, coming and going, which she says this never does. The prognosis is good, but she may be subject to the same eruption next spring unless some change is made in her mode of life or prophylactic measures are instituted.

Case III. *Impetigo.* You have before you in this girl ten months old, what I believe we should recognize as the impetigo of older writers; for perhaps you know that some recent authors have excluded the term impetigo from nomenclature except as associated with eczema or as applied to the impetigo contagiosa. Now in this

case there is no element of eczema; those pustules which have been scratched or rubbed show no tendency to run together or to exude, there is no thickening of tissue, nor is there any amount of itching or irritation, there are almost no evidences of scratching. Nor have we any of the elements of the impetigo contagiosa; there are four other children in the family, and none have taken it, nor has the mother; there are none of the brown-paper like crusts, indeed the pustules show very little tendency to crust at all; they are all very acute. The whole body, limbs and head you see are covered with a scattered but pretty thickly set eruption of pustules, very many of them still contain pus, mostly yellow, some of them quite pale in color; there is not much inflammatory action around them. The pustules are mostly small, and contain a relatively large amount of pus, differing in this from furuncles.

The first suggestion arises, is not this a case of scabies; the eruption on the hands and feet resembles this very much. But the most careful examination fails to discover any traces of the acari, and, moreover, some other members of the family would be pretty certain to be affected—there are four children. The ever present syphilis suggests itself, but this is not a pustular syphilide; the pustules are too acute; there is no crusting, and the region around the anus is entirely free from eruption, which is seldom if ever the case in congenital syphilis.

The child appears to be in good health, and is very fat; the bowels move daily once or twice, the child nurses only. The present eruption is not serious in character, and would probably pass away without treatment in a reasonably short time. The main points are to avoid local irritation, and for this purpose we will order a little zinc ointment; we will also give a little rhubarb and soda mixture, as the mother says that the passages from the bowels are offensive.

(TO BE CONTINUED.)

Society Transactions.

NEW YORK DERMATOLOGICAL SOCIETY.

REPORTED by DR. G. H. FOX, SECRETARY.

Eightieth Regular Meeting, January 9, 1877.

THE following cases were exhibited before the Society.

I. Lupus erythematosus, by Dr. Bulkley.
II. " " by Dr. Bulkley.
III. Lupus vulgaris, by Dr. Bulkley.
IV. " erythematosus, by Dr. Bronson.
V. Psoriasis buccalis, by Dr. Bronson.
VI. Psoriasis of penis, by Dr. Fox.
VII. Chronic circumscribed inflammation of corpora cavernosa, by Dr. Taylor.

DR. BULKLEY's first case of *lupus erythematosus* was in a young German girl aged 11 years, in whom the disease had lasted for something over six months. The face was occupied by a dark colored eruption of erythematous lupus, which covered the bridge of the nose, the cheeks down to the chin, sparing the mouth, most of the forehead, and the ears, and existed upon both the backs of the hands and the palmar surface of some of the fingers. The amount of the brownish, scaly, crusting was slight, but it was very adherent upon certain portions, as on the ears and nose, and when pulled off the scales showed the prolongations which extended into the sebaceous glands.

DR. BRONSON referred to the confusing nomenclature of lupus, and to the points of difference between lupus erythematosus of the English and lupus erythematodes of the Germans.

DR. KEYES mentioned the sebaceous element as being characteristic of the latter.

DR. ROBINSON said that the lupus erythematosus of the English was simply a mild form of lupus vulgaris. He thought that the sebaceous glands were not primarily involved in the lupus erythematodes of the Germans, but that the disease began with an enlargement of vessels with surrounding cell-infiltration as shown in observations by Thin. He regarded the present case as one of lupus erythematodes, with an eczematous condition of the hands.

Dr. Piffard said that if he had seen the case casually he would have called it a severe eczema, that might improve speedily under proper treatment. And whatever doubt might now exist as to its nature he would treat it as an eczema. The condition of the hands was that of papular eczema and not lupus. As for the sebaceous plugs to which attention had been called, they might also be found beneath the scales of eczema.

Dr. Sherwell, in speaking of the age of the patient in reference to diagnosis, mentioned a case of undoubted lupus erythematosus occurring in a child of 8 years.

Dr. Keyes spoke of the affection as occurring upon the back of the hand on an 3-year old baby suffering from Potts' disease. In this case a cicatrix formed without any shedding of the epidermis.

Dr. Bulkley exhibited a second case of *erythematous lupus* occurring on a woman of 26 years. The eruption bore a very great resemblance to syphilis, and the patient had been given the benefit of the doubt, and had taken anti-syphilitic treatment for three or four months, without its producing any appreciable change in the lesion. The disease was in isolated patches, one upon the bridge of the nose, where a rather thick crust was very firmly adherent, but on being drawn off, it showed the sebaceous prolongations very plainly. Several patches existed on the cheeks, and both ears were affected in a manner very similar to those of the former patient, the child with erythematous lupus: namely, they were covered with a dry, brownish crust, firmly adherent, and prolonged into the sebaceous orifices. The anterior cervical glands were much enlarged on both sides, and had been so for a long time, their size had varied greatly at times, but did not change for the better under the anti-syphilitic treatment.

Dr. Emerson thought the disease resembled tubercular syphilis in a condition of retrogression, but would not venture an absolute diagnosis except by daylight.

Dr. Keyes thought the appearance of the eruption suggestive of inherited syphilis, and that its course was not characteristic of lupus erythematosus. He could not actually pronounce it as being syphilitic, but suggested that Dr. Bulkley inquire carefully into the patient's parental history, &c. It might be lupus upon a syphilitic base.

Dr. Bulkley stated that the patient had been for six months under treatment for syphilis.

Dr. Keyes alluded to the coexistence of syphilis and scrofula, and cited two cases.

Dr. Fox indorsed the view of Dr. Keyes that these two diseases might combine in producing a given lesion. A young man, recently under his care, had suppurating cervical adenitis as a child. A short time after contracting syphilis the anterior cervical glands enlarged and finally ulcerated. The appearance of the ulcers was not typical of either disease. The progress towards healing was unusually slow under mercurial treatment, but cod liver oil internally hastened the cure.

Dr. Bulkley's third case was a very typically severe one of *lupus vulgaris*, affecting the whole face and causing much disfigurement. The patient, a widow woman, 44 years of age, had borne the disease for thirty-one years, it commencing upon the side of the nose when she was 13 years old. She had been submitted to most varied treatment, during a great part of this time, but with continued increase of the disease. The greater part of the face, cheeks and ears was covered with a tuberculous eruption, of a dark, coppery red, with thin scales over a larger portion of it, and some crusting in places. The end of the nose had been destroyed, the lips were thickened, cracked and ulcerating slightly in some places. During the last two months since she had been under treatment by Dr. B., the disease had appeared to be arrested under the internal use of phosphorus, but no definite report could yet be made of the case therapeutically.

Dr. Bronson presented a large stout man with an unusual red patch upon one cheek, which he was inclined to regard as a patch of lupus.

Dr. Bulkley had seen such cases yield to the ordinary treatment of acne, and thought the eruption to be acne rosacea.

Dr. Keyes thought the affection resembled lupus erythematosus more than it did acne.

Dr. Robinson spoke of a patient with erythema multiforme, who had a somewhat similar patch upon the face, which he called lupus at the time, but which afterward proved not to be this affection.

Dr. Bronson said he had made a positive diagnosis of lupus erythematosus in this case at first, but its appearance had changed so rapidly that he was now in doubt.

Dr. Bronson introduced a patient with a whitish patch upon the buccal mucous membrane.

Dr. Keyes diagnosed it as syphilitic.

Dr. Fox doubted the syphilitic nature of the affection in this case, and spoke of cases which he had observed in which neither a syphilitic history, nor benefit from use of anti-syphilitic remedies, could be obtained.

Dr. Keyes said that the use of tobacco would prevent the effects of the internal treatment for syphilis. He suggested stopping the use of tobacco in this case, and then adopting specific treatment.

Dr. Piffard mentioned a case of ichthyosis of the tongue of ten years' standing. The patient was pronounced syphilitic and had been under the care of Ricord for three months. Considering the doubt existing as to the nature of this affection, Dr. P. suggest the provisional name of "*Alphelasma*," or white lamina.

Dr. Bronson alluded to the improvement in this case under mercury and iodide of potassium.

Dr. Keyes mentioned the beneficial effect of local calomel fumigation.

Dr. Robinson advised the use of nitrate of silver locally, but cautioned against the danger of inducing bronchitis.

DR. FOX exhibited the following case of psoriasis of the penis:

David M., aged 24. A scaly patch first appeared upon the prepuce and glans penis nine years ago. It has disappeared several times, but after remaining away for a few months, has reappeared in the same location, gradually extending backward towards the root of the penis.

Four years ago the scalp became affected, and a single psoriatic "drop" appeared on calf of left leg. The eruption on the scalp and leg disappeared a year ago under treatment, but the single guttate scale soon reappeared on calf of the leg in very nearly, if not exactly, the same spot. The case is peculiar, inasmuch as the eruption affects the penis, which is rare, and has never appeared about the elbows or knees, the favorite locality of psoriatic patches.

DR. BULKLEY mentioned a case of psoriasis involving the penis with other portions of the body, and co-existing with buccal psoriasis or the so-called "alphelasma."

DR. KEYES mentioned a case in which the psoriaris was limited to a single patch on the dorsum penis.

DR. TAYLOR exhibited the following case of *Laminar Tumor of the Corpora Cavernosa.*

R. O'C., æt. 55, born in Ireland, has been married twice, the first time when 25 years of age; has been the father of 11 children; occupation always that of tailor. Has always been healthy; had pneumonia and attack of ague a few years ago; is a strong, stout, fair appearing, hearty regular; has had gonorrhœa twice, the first time when 24 years old, lasting about nine months, the second time when 45 years old, lasting about 3 months, both times of very acute character with much chordee. Neither times, after the *final disappearance*, was there afterwards a gleety, irregular discharge; never any symptoms whatever of urethral stricture. Never had orchitis, nor is there varicocele. Both times he had gonorrhœa, there were also two or three sores present upon the glans penis, evidently chancroids, herpes or other local lesions, as no history of syphilis, past or present can be obtained. Children healthy. Sometime last June (1876) he first noticed that whenever he had an erection, there was a twinge of pain from about the middle of penis, shooting along the urethra to meatus; examining his penis, he found "a small, hard lump" right on the top and middle. These erections were always accompanied by a bending upwards of the organ, beginning just in advance of the "hard lump," "a little chordee," as he calls it.

At first it felt to him "like a pea" just in the centre and dorsum of the penis; at present it extends from about this point one inch backwards, is a flat, elastic lamina embracing both cavernous bodies, as he says, "like a lima bean," it is quite tender and sensitive over any part of its surface, the point of origin in about same condition as at first; the skin of the organ is in no way involved; he knows of no disease, accident or injury which can be assigned as the cause; is not, nor never was, specially addicted to sexual intercourse, masturbated to some extent before marriage; no nocturnal emissions; sexual intercourse not seriously impeded except from

pain; pain more severe when standing; "sensation like a burning heat," as he expresses it, during, or at time of erection. This patient came to the Skin Clinic of Dr. Taylor at Bellevue Dispensary Dec. 21st, 1876.*

In the discussion Dr. Taylor called attention to two lateral processes extending towards the glans penis, and suggested for the name of the affection "laminated tumor of the penis."

Dr. Keyes remarked that it was a typical specimen of the disease which he had brought to the notice of the Society on a former occasion under the name, *chronic circumscribed inflammation of the corpora cavernosa*. It was first described by Johnson of London, and Warren of Boston. The erectile tissue of the corpora cavernosa and sheath was involved, but not the sheath of the penis. He objected to the use of the term tumor.

Dr. Bulkley had observed two cases occurring in syphilitic subjects.

Dr. Taylor referred to a case in which two lateral horns apparently followed the lymphatic vessels down to either side of the frænum.

Dr. Taylor presented to the Society "*Des Syphilides palmaires et plantaires*, par Madier-Champvermeil.

* (Note in June 1877.)
Under the influence of large doses of the iodide of potassium and of the rather constant application of half strength mercurial ointment, he has been very much benefited, both as to the subsidence of the tumor and the relief of the symptom of bending of the penis.

Digest of Literature.

I.

DISEASES OF THE SKIN.

ETIOLOGY, THERAPEUTICS, GENERAL TOPICS.

EDWARD B. BRONSON, M. D.

1. **Testut.**—General pathology of diseases of the skin. Gaz. des Hôpit., p. 225, March 10, 1877.

2. **Guibout, E.**—The arthritic diathesis. L'Union Méd., No. 37, March 29, 1877, and No. 38, March 31, 1877.

3. **Meyer, F.**—The influence of the moral emotions in the development of cutaneous affections. Review in Lyon Méd., p. 462, Nov. 26, 1876.

4. **Tibbits, E. T.**—On the probable relationship of syphilis, scrofula, tubercle, cancer, etc. Lancet, p. 890, Dec. 23, 1876, and 972, Dec. 30, 1876.

5. **Pick.**—The relations of diseases of the skin to diabetes. Allgem. Wien. Med. Zeit., No. 34, 1876. (Med. and Surg. Reporter, p. 495, Dec. 9, 1876.)

6. **Pick.**—The relation of diabetes to skin diseases. Medicinisch Chirurg. Centralbl., No. 34, 1876. (Monthly Abstract, p. 70, Feb., 1877.)

7. **Vidal.**—Local temperatures in skin affections. Soc. de Biol. Le Prog. Méd., p. 289, April 24, 1877.

8. **Ganghofner and Pribram.**—The constitution of the urine in melanosis. Viertelj. für die Prakt. Heilk. II., 77, 1876. (Rev. des Science Méd., p. 53, Jan., 1877.)

9. **Testut.**—Symmetry in affections of the skin. Paris, A. Delahaye & Co., 1877. (Gaz. Hebdom., p. 128 and No. 23, 1877.)

10. **Bulkley, L. D.**—Analysis of seven hundred and seventy-four cases of skin disease treated at the Demilt Dispensary during the year 1876, etc., etc. N. Y. Med. Jour., p. 357. April and June, 1877. Reprint, D. Appleton & Co., New York.

11. **Greenough, F. B.**—Notes on some of the more frequent forms of skin disease. Boston Med. and Surg. Jour., February 22, 1877.

12. **Pepper, Wm.**—A case of Addison's disease. Am. Jour. Med. Sciences, p. 75. Jan., 1877.

13. **Pepper, Wm.**—Addison's disease and its relations with anæmatosis (essential anæmia). Am. Jour. Med. Sciences, p. 329, April, 1877.

14. **Pye-Smith, P. H.**—Two cases of Addison's disease. Br. Med. Jour., Dec. 9, 1876.

15. **Butler.**—Case of Addison's disease. Royal Surrey Co. Hosp. Lancet, p. 458. March 31, 1877.

16. **Duffey, Geo. F.**—A case resembling one of Addison's disease. The Dublin Journal of Med. Sci., March, 1877. (Med. Press and Circular, p. 201, March 14, 1877.)

17. **Milroy, Gavin.**—On yaws and some allied diseases. Med. Times and Gaz., Nov. 4, 1876, and February 17, 1877.

18. **Thin.**—Rare form of skin disease. Royal Med. and Chirurg. Soc. Lancet, p. 235, Feb. 17, 1877.

In the January number of the American Journal of Medical Sciences, Dr. PEPPER (12) published a very complete history of a case of Addison's disease, including an account of the post-mortem examination. In the following (April) number of the journal comments are made upon this case, while the subject of the disease in general is given a tolerably full discussion (13). Some of the considerations presented are, to a certain extent, new. The most novel as well as most interesting feature of the article is the suggestion of a relationship between Addison's disease and progressive pernicious anæmia. In a former paper the writer had already shown the close alliance that exists between the different forms of leucæmia and progressive pernicious anæmia in their common dependance upon defective elaborations of the blood, and for this general condition underlying them all he had proposed the term *anæmatosis*. The writer endeavors now to show that Addison's disease is likewise an anæmatosis. This he does by pointing out the close correspondence between the symptoms, and, to a certain extent, the pathological anatomy of this disease and those of progressive pernicious anæmia. For the purpose of indicating the relation more clearly, the characteristic features of the two diseases are tabulated side by side. The resemblance is certainly very striking; whether or not it implies community of origin can only be determined after further investigation. Jaccoud, Greenhow, and others, it is well known, refer all the symptoms of the disease solely to irritation of the abdominal sympathetic nerves and ganglia, occasioned by the disease of the supra-renal capsules. Pepper, on the other hand, while not denying that this has an important share in the production of the disease manifestations, would "call attention to the importance also of the blood changes and the signs of constitutional infection in this disease," and to the necessity of "more careful observation of the morbid appearances in those situations chiefly affected" in the leucæmic diseases, namely, the spleen and marrow of the bones. "I do not think," he says, "the microscopic examinations of the blood and tissues have yet been sufficiently numerous and accurate to enable a positive opinion to be expressed; but I incline to the belief that the essential pathology of Addison's disease may prove to embrace both elements, as follows: a primary chronic degenerative inflammation of the supra-renal capsules;

constitutional infection, with the production of secondary caseous deposits (or, in some cases, of tuberculosis); impairment of the blood elaboration (anæmatosis), possibly with lesion of the marrow of the bones or of the splenic pulp; consequent fatty degeneration of the heart; extensions of irritation from the capsules to the nerves connected with them, to the semilunar ganglia and to the solar plexus." While thus in general terms he expresses his views of the pathology of the disease, the writer does not wish to be understood as stating the different factors precisely in the order of their occurrence nor of their relative importance. "But," he observes, "it is evident that upon the predominance of one or the other of these factors will depend certain peculiarities of individual cases."

With regard to the discoloration of the skin which occurs in Addison's disease, the writer accepts the view generally maintained by pathologists at the present time, namely, that it depends upon irritation of the abdominal sympathetic communicated to the vaso-motor nerves of the skin, with the production of abnormal deposits of pigment. But it is urged that this is a symptom of only casual importance and should not be regarded as essential nor pathognomonic. The facts that other abdominal diseases—chronic peritonitis and some uterine affections, for example—may, by irritation of the sympathetic nerves, give rise to bronzing of the skin as marked as in Addison's disease; that other diseases of the supra-renal capsules beside that under consideration, such as cancer, tubercle or hæmorrhage, not attended by the peculiar cheesy degeneration and sclerosis of the capsules which characterize Addison's disease, cause no discoloration of the skin, prove that this symptom is not the result of any loss or disturbance of function in the supra-renal capsules, but requires some other explanation. It is only in connection with the constitutional symptoms the writer would claim that it has any great significance. In view of the connections of the disease with the group of blood affections already mentioned, the writer makes use of the expression, "anæmatosis with bronzing of the skin," at the same time disclaiming any wish to displace the name *Addison's disease*, by which it is so generally known, until the pathological questions involved shall have been fully settled.

Dr. Milroy (12) has been contributing some interesting observations on framboesia or yaws to the Medical Times and Gazette. Two articles have already appeared and another is to follow. It has been generally supposed that yaws was only indigenous on the western coast of Africa, and that the disease was thence transmitted to the West Indies. The writer, after fully describing the malady as it exists in these countries, and as he had himself observed it in the West Indies, proceeds to show that its geographical limits are by no means confined to the above regions, but that certain affections have been elsewhere described, sometimes under other names, whose points of similarity to yaws furnish a strong presumption of their nosological identity.

"The distinctive characteristic of yaws," Milroy observes, "is the eruption of raised or tuberculate pustules of a round or ovoid

form, which become covered with a yellow or brownish scab or crust, and from which, on the detachment of this crust, there extrudes a raw-flesh fungus, resembling somewhat by its reddish color and granulated surface, the appearance of a raspberry (*framboïse*)." The fungous excrescence varies much in size, color, and form, depending upon "its situations, the chronicity of the case, the age of the patient, and the cachexia of the constitution." The surface is usually moist and covered with a viscid discharge. "Sometimes, on the falling off of the crust, the rounded raw-flesh surface is quite smooth and flat, or but little raised above the adjacent skin; or more rarely it becomes somewhat hollowed out, the edges being considerably above the level of the centre of the sore." It is not generally sensitive to touch nor to pressure. The discharge is scanty and of an unhealthy character. The most common situations of the eruption are "the face, neck, shoulders, front of the chest, and the extremities, and it often occurs also about the pudenda and in the neighborhood of the anus." The tuberculate pustules are usually discrete, but are sometimes clustered together. Occasionally they assume a crescentic or annular arrangement, enclosing in the centre a portion of sound skin—"the 'ring worm yaws' of the West Indies." In children it is common for the eruption to assume the form of a ring about the mouth or anus, the tubercles coalescing to form a circular projecting band. The throat and mouth are said to be rarely affected, and then only in cases of long duration. When the disease has persisted for a long time the constitution becomes depraved, giving rise to the development of other forms of eruption of a pustulous or eczematous character. In such cases, especially when neglected, the earlier marks of the yaw-eruption give place to a marked tendency to serpiginous ulceration at the seats of the disease. The ulcers are apt to linger for a long period, involving often extensive surfaces, with the production ultimately of permanent disfigurement or deformity. Important joints may then become completely disabled.

Such being the course of the true yaw disease, the author proceeds to compare with it two other affections, which, though known by special names, bear so close a resemblance in their characters to frambœsia that they are believed to belong to one and the same family. One of these is the so-called "Parangi disease" of Ceylon. This affection has been described by Dr. Loos, colonial surgeon of Ceylon, in an official report made in 1868, and entitled, "Depopulation of the Vanni District." A further contribution on the same subject was made by Dr. Danforth, assistant colonial surgeon, in 1873. The disease begins with an eruption which, according to Loos, "is either pustular or tubercular; less frequently scaly." Danforth, on the other hand, states that most frequently the disease starts with a psoriasis, and is often associated with fissures of the skin, especially in the palms and soles. "Next in frequency," he says, "are the tubercles; some of these are small, rounded, hard, and elevated above the level of the skin, developing in small circular groups, with healthy skin intervening, and forming a small centre

to each patch ; while others are large, soft, isolated, and little elevated above the surface. These are scattered over the whole surface of the body. The vesicular and pustular varieties are not of very common occurrence, and are chiefly found in children of a broken constitution." As the disease continues, ulceration sets in. The ulcers are circular, with elevated edges, spreading widely and deeply destroying the affected parts. The discharge is ichorous and not very copious. In general the course of the disease is very similar to that of yaws. With regard to the fact of the fungous excrescence so characteristic of the latter disease not being mentioned by Loos and Danforth in connection with parangi, the writer observes that in an account of the same affection by Mr. Marshall, published forty years ago, it is stated that the ulcers occasionally "became the seat of a large excrescence."

The other disease referred to by M. as being closely related to yaws, is the "Copo" disease of Fiji. As described by Dr. Macgregor, the chief medical officer of the new colony, this affection first manifests itself as a pustulo-tuberculate eruption which occurs "especially on the face, around the mouth, nostrils, and eyes, and about the neck." It may become scattered over the whole body. The tubercles are usually of a circular form, or elongated, elevated above the surrounding skin sometimes to the extent of half an inch. Occasionally they are ring-shaped, with a spot of sound skin in the centre. The surface ulcerated, and, on removing the thin crust that forms, an appearance is presented which seems to bear a close resemblance to the raspberry-like fungus of framboesia.

Finally two cases of yaws are cited by M. as showing that the disease is necessarily confined to no particular countries. The first is reported by Dr. Adams in his work on "Morbid Poisons," and occurred at Madeira. The second, which came under the writer's own observation, was met with in England, and this case is reported at considerable length. The subject is to be continued by Dr. Milroy in a further number of the Journal, the topic of treatment not yet having been touched upon.

19. **Aillaud, F.**—Study of some forms of simple inflammation, &c. (*Etude sur quelques formes d'inflammation simple de la peau, décrites sous les noms de pityriasis, dermatite exfoliatrice généralisée.*) J. B. Baillière et fils. Paris.

20. **Gousset, F.**—Contribution to the study of cutaneous eruptions in surgical diseases. Thèse de Paris, 1876. (Rev. des Sciences Méd., p. 263, Jan., 1877.)

21. **Tremblez.**—Cutaneous eruption following in the course of surgical affections. Thèse de Paris, No 372, 1876. (Gaz. des Hôpit., p. 71, Jan. 23, 1877.)

22. **Purdon.**—The diseases which prevail among workers in flax. The Dublin Journal of Med. Sciences, Nov., 1876.

23. **Dumas.**—Eruptions produced by quinine. London Med. Record, Oct. 16, 1876.

24. **Bergeron** and **Proust.**—Quinine eruption. Ann. d'Hygiène pub. et de Med. Leg. 2d serie, xlv., p. 482, et xlvi. 17. (Rev. des Sciences Méd., p. 215, Jan. 7, 1877.)

25. **Denig, R. M.**—Quinine; case of idiosyncracy in regard to its action. Ohio Med. Recorder, 1877, March, p. 447. (Chicago Med. Journal and Exam., p. 475, May, 1877.) (An eruption caused by internal administration.)

26. **Pinsker.**—Skin eruption from bromide of potassium. Lon. Med. Record, Dec. 15, 1876. (Monthly Abstract, p. 70, Feb., 1877.)

27. **Boubila.**—Some considerations in simple ulcer of the limb. Thèse de Montpellier, No. 13, 1876. (Gaz. des Hôpit., p. 127, Feb. 8, 1877.)

28. **Lailler.**—Ulceration of the face and neck. L'Union Méd., p. 256, Feb. 13, 1877.

29. **Siredey.**—Ulcerations of the vulva. Centralblatt f. d. Med. Wissen., March 24, 1877.

30. **Alekschieff P.**—Emphysema of the skin during parturition. Russich Med. Rundschau, Bd. 2, 1876. (Phys. & Pharm., Feb., 1877.)

31. **Savoy.**—Contribution to the study of eruptions of the conjunctiva (*Contribution a l'étude des eruptions de la conjonctive.*) Paris, Delahaye & Co., 1876.

32. **Otis, F. N.**—Precautions against communicable diseases of the skin and syphilis. Ohio Med. and Surg. Journal, Dec., 1877. (Half yearly Comp. of Med. Science, Jan., 1877.)

33. **Bradley, S. Messenger.** On precision in the use of topical remedies. Med. Times and Gaz., Nov. 11, 1876.

34. **Hebra.**—The action of water upon the healthy and diseased skin. Wien. Med. Woch., Jan. 6 and 13, 1877. (Lond. Med. Record, March 15, 1877.)

35. **Pleniger.**—Critical eruptions in hydropathy. Wien. Med. Wochensch., March 3, 1877.

Prof. Hebra's paper (34) is not in all respects a satisfactory one. The design of the article seems mainly to have been to controvert prevalent theories which to the vigorous mind of the writer appear too much like gratuitous assumptions. In most instances therefore the arguments are destructive rather than constructive; and, where the writer advances theories of his own the supporting evidence is not so clearly presented but that one is left with a suspicion that they also may be not unassailable.

The common belief that frequent bathing serves as a preventative of disease is first made the object of attack. There are millions of people, he says, whose bathing consists in once a week washing the hands and face, and that not very thoroughly, who yet rejoice in the best of health. Again, it is urged that the prevalence of disease in cities, where bathing is comparatively common, is vastly greater than in the country where the bath is a rarity, he claims, and frequently cannot be obtained even in cases of necessity. The natural inference from this would be that bathing not only does not prevent but promotes disease. No such conclusion, however, is drawn by the writer. But as to any beneficial influence which our ablutions may have upon the general health or upon the cutaneous function the writer is silent. Indeed he speaks of bathing as simply a pleas-

urable indulgence, while we are warned that it is a pastime which, when carried to excess, may become the means of serious damage to the skin. This is evinced in the production of various eruptions which formerly at the water cures were regarded as denoting certain critical events through which the materies morbi was eliminated (PLENIGER 35).

The irritating cause of these eruptions has been referred to the temperature of the water, but this view is rejected by Hebra entirely. He appears disposed to deny to the temperature of the bath any therapeutic effect whatever. So far as the skin is concerned he claims that such extremes as 90° and 104° Fahr., have precisely identical effects. He says that he has treated furuncles and carbuncles with ice bladders and with hot poultices, and the results were the same, the disease running just the same course in the one case as in the other. Views based upon the abstraction of heat from its body through the application of water are accorded but slight importance. With regard to the beneficial effect of the cold bath or wet pack in scarlatina or enteric fever, he incidentally remarks that it has not been substantiated, statistics not having proved that cases treated in this way show any less degree of mortality than where purely expectant treatment is pursued.

The irritating effect of the water is attributed by Hebra solely to the maceration and consequent destruction of the epidermis. The upper layers being destroyed the deeper, younger layers of cells are exposed and the surface becomes more vulnerable. Little red pimples first appear, then coalesce into red patches, and gradually an eczema is developed. Hence when the skin is sensitive, irritable, and liable to eruptions, when in a state of acute œdema or infiltration, or when the superficial layers have already been removed through disease or irritating measures of treatment, the bath is regarded as contra-indicated.

On the other hand, the macerating effect of water is made available to the treatment of many skin diseases. Thus it is used in psoriasis, ichthyosis, pityriasis rubra, and lichen; or where it is desired to soften a dry hypertrophied epidermis and irritate a thickened subjacent cutis, as in long standing eczema and prurigo. The bath is further employed for the removal of hurtful secretions, and again to promote the growth of epidermis through the exclusion of the air, as in pemphigus and extensive destruction of the skin from burns and corrosives.

As to the duration of the bath, it is determined entirely by the feelings of the patient and the effects produced. For many years Hebra has been in the habit of keeping certain patients in a continuous bath of days, weeks or even months' duration. In one case it was maintained for a period of nine months. He has found that under these circumstances the patient eats, drinks, and sleeps as though out of the bath, while respiration, excretion and the general nutrition are in no wise prejudiced. The results thus obtained in many forms of skin disease of the most distressing and intractable character, have been exceedingly satisfactory. Such conditions

as menstruation, epilepsy, &c., which have been regarded as contra-indicating the bath, have not interfered with its safe continuance. In one instance during an attack of pleuro-pneumonia, the bath was not interrupted and the case did not thereby suffer.

37. **Auspitz, Heinrich.**—On the mechanical treatment of diseases of the skin. Vierteljahress. f. Derm. u. Syph. 1876. Heft IV., p. 562.

38. **Dron, A.**—The curette in the treatment of some cutaneous affections. Lyon Méd., p. 115, Jan. 28, 1877.

39. **Ellinger.**—Sand-rubbing in skin diseases. Wien. Med. Wochensch., Nov. 4, 1877.

40. **Arnold.**—Contribution to the study of the treatment of ulcers by electricity. Thèse de Paris, No. 74, 1877. (Le Prog. Méd., p. 217, March 17, 1877).

41. **Golding Bird.**—Electricity in ulcers. Guy's Hospital Reports, 1876. (The Med. and Surg. Reporter, March 24, 1877.)

42. **Neumann.**—Galvano-caustic in skin diseases. Lond. Med. Record, Dec. 15, 1876. (Monthly abstract, p. 70, Feb., 1877.)

43. **Piffard, Henry G.**—On the actual cautery and its em. ployment in cutaneous surgery. Charleston Med. Journal and Rev., Jan., 1877.

44. **Prowse.**—The method of bandaging in ulcers of the leg. The British Med. Journ. (The Med. and Surg. Reporter, May 19, 1877.)

45. **Ory.**—Treatment of herpetic affections. Le Prog. Méd., Sept. 30, 1876.

46. **Ory, E.**—Treatment of fissures of the nipples. La France Méd., p. 776, Nov. 29, 1876.

47. **Ory, E.**—Treatment of cutaneous deformities. Le. Prog. Méd., p. 3., Jan. 6, 1877.

48. **Von Mosetig.**—On the treatment of ulcers of the leg. (N. Y. Med. Jour., p. 438, April, 1877.)

49. **Golding Bird.**—On the treatment of scrofulous lymphatic glands by a painless electrolytic caustic. Lancet, p. 567, April 21, 1877, p. 605., April 28, 1877.

50. **Besnier, Ernest.**—Method of lessening the pain attending blisters. London Medical Record. (The Med. and Surg. Reporter, March 24, 1877.)

51. **Squire, Balmanno.**—On a glycerole of nitrate of bismuth as a remedy in skin diseases and in some other conditions. Med. Times and Gaz., Dec. 9, 1876, and Jan. 6, 1877.

52. **Woodman.**—Tayuya—A new remedy for syphilis and scrofula. Lond. Med. Record, April 15, 1877.

53. **Pedrelli, Mario.**—Chlorate of potash and mercury. Bull. delle Scienze Mediche di Bologna, Guigno, 1876. (Lo Sperimentale, Settembre, 1876, p. 251.)

54. **Van Holsbeck.**—Antiseptic ointment. L'Union Méd., p. 12, Jan. 4, 1877.

℞. Acid Salicylic, 4 grammes.
Ol. Amygd. dulc, 2 grammes.
Axonge 30 grammes. For indolent ulcers.

55. **Salicylic Soap.**—(Messrs. Tidman & Son, Wilson Street, Finsbury, London.) Med. Times and Gaz., Nov. 11, 1876.

Sanitary Eucalyptus Oil Soap. (Messrs. Whitaker & Grossmith, Fore Street, London.) Med. Times and Gaz., Nov. 11, 1876.

56. ——. Iodide of ammonium in syphilis and scrofula. **L'Union Méd., p. 71, Jan. 13, 1877.**

57. **Kirk, Robt.**—On the external use of salicylate of iron. **Edin. Med. Jour., p. 707, Feb., 1877.**

58. **Wiss.**—Peruvian basalm as a dressing for wounds. Berl. Klin. Woch., Nov. 27, 1876. (Brit. Med. Jour. Dec. 16, 1876.)

59. **Perrant.**—Bromide of potassium as a caustic. Med. Times and Gaz., Sept. 23, 1876.

60. **Charner.**—Picric acid for sore nipples. Pacific Med. and Surgical Journal (Southern Med. Record, p. 734, Dec., 1876.)

61. **Chauvir.**—Use of picric acid for sore nipples. Gaz. des Höp. (Wien. Med. Wochensch., Sept. 9, 1876.)

62. **Le Diberdier.**—Quinine in the treatment of fissures of the nipple. Med. Press and Circular, Dec. 20, 1876.

63. **Day, John.**—On the use of peroxide of hydrogen for the prevention of the spread of scarlet fever and small pox. March 10, 1877.

64. **Van Harlingen, A.**—Convenient mode of dispensing ointments. Phil. Med. Times, p. 319, April 4, 1877.

Auspitz' long and interesting article (37) *on the mechanical treatment of diseases of the skin* hardly admits of condensation. It contains full reference to the works of others, and but little that is really new.

M. Deos (38) writes favorably of the use of the curette in the treatment of skin diseases. Lupus, epithelioma, rodent ulcer and venereal warts are the affections in which he has found it especially serviceable. In lupus of the face however, he objects to the instrument because of the red discoloration which remains after it has been used; in one case under his observation it had not disappeared four months after the operation. Therefore when the lupus is situated in the face, the writer prefers the actual cautery whenever it can be employed with safety. If the use of the actual cautery in the face, or any other part of the body where diseased tissue is to be destroyed, would be attended with danger on account of the liability of destroying tissues beyond the seat of disease, as for example in the vicinity of the mucous orifices (where atresia might result), the writer recommends scraping the part and afterwards cauterizing with nitrate of silver. He has found the curette most frequently useful in extirpating vegetations, especially when sessile. After they have been scraped away he touches the little wounds that remain with the perchloride of iron, which has the

double effect of staunching the hemorrhage and preventing recurrence of the growths.

Dr. Ellinger, of Stuttgart (39), recommends in the treatment of numerous diseases of the skin, scrubbing the parts with sand. He used it first for the acne and comedones that so often disfigure the faces of young people. Afterwards it was employed successfully in lentigo, pityriasis versicolor, acne rosacea, eczema, psoriasis, prurigo, and psoriasis syphilitica palmaris. The sand used must be composed of medium coarse grains varying in size from that of poppy seed to half that size ; nor should the sand contain too much dust, which would make it ineffective. The writer employs two sorts, one finer for the face and more tender portions of the skin, and another coarser for the body and extremities. His method consists in keeping the surface moist for a considerable time, and then rubbing it with moistened sand, which is finally washed or brushed off. If it be the face that is to be operated upon, it is washed at night with soap and kept moist for half an hour before the sand is used. On the body or extremities Priessnitz' water dressing is applied before the rubbing is begun. Where extensive portions of the body are involved, the patient is kept in a bath for an hour or two, then washed with soap, and finally scrubbed with the sand. A paste is also recommended consisting of sand and carbonate of potash (1.5) and water.

Some months ago Squire described a solution of the subacetate of lead in glycerine, which he had found a very valuable remedy for eczema and other affections. He has since discovered (51) that glycerine is also a solvent of the nitrate of bismuth. The solution first prepared was of the strength of a drachm to the ounce. It was ascertained that if freshly prepared, without the aid of heat, this glycerole could be largely diluted with water without causing any precipitation except after long standing. Thus diluted it is suggested that the solution will afford a means of administering bismuth both internally and externally in a much more efficacious form than that presented by the dry subnitrate in common use. In all cases where a mild sedative astringent is indicated, as in diseases of the stomach, throat, urethra or skin, it is believed that it will be found greatly superior to the dry powder. But the caution is given that, because of the greater activity of the soluble salt it should be given in smaller doses than the powdered subnitrate. A solution of two grains to the ounce was found to be of sufficient strength as an application for eczema.

The tayuga plant (52) has been recently introduced into Italy by the naturalist Signor Luigi Ubicini, of Milan. Its root is used by the natives of Brazil as a remedy against syphilis. Two tinctures are used, the weaker being given internally in doses of 2–20 drops two or three times a day.

Van Harlingen (63) revives a method of dispensing ointments first suggested some years ago by a Parisian apothecary. The plan consists in pouring the ointment when melted into soft metallic tubes provided at one end with a screw cap similar to those

in common use by painters. When filled the open end is folded in. A great objection to the use of many valuable ointments, notably Hebra's diachylon ointment, is their liability to become rancid on exposure to the air. By means of the above simple device they may be preserved indefinitely, while at the same time they are in a most convenient form for administration.

INFLAMMATIONS; ACUTE AND CONTAGIOUS.

FRANK P. FOSTER, M. D.

1. **Foerster, R.**—On the modes of diffusion of measles and scarlet fever. (*Einige Bemerkungen über die Verbreitungsweise der Masern und des Scharlachs*). Jahrb. f. Kinderheilk., x Bd., N. F., Aug. 15, 1876, p. 164.

2. **v. Huettenbrenner, A.**—On second attacks of the exanthematous fevers, particularly scarlet fever. (*Ueber zweimaliges Auftreten von acuten Exanthemen, insbesondere von Scharlach.*) Jahrb. f. Kinderheilk., x Bd., N. F., Nov. 30, 1876, p. 334.

3. **Hogg, F. R.**—Notes on infantile diseases in India. 1.—Scarlet fever. Med. Times and Gaz., Sept. 2, 1876, p. 253.

4. **Olshausen, R.**—On puerperal scarlet fever. (*Untersuchungen über die Complication des Puerperium mit Scharlach und die sogenannte,* "Scarlatina Puerperalis.") Arch. f. Gynäkologie, IX. Bd., 2 Hft., p. 169.

5. **Liebmann, C.**—Three cases of puerperal scarlet fever. (*Drei Fälle von Scharlach bei Wöchnerinnen*). Arch. f. Gynäkologie, x. Bd, 3 Hft., p. 556.

6. **Sutherland, D.**—Case of puerperal scarlatina. Ed. Med. Jour., Nov., 1876, p. 446.

7. **Malone, M. J.**—Unusual sequels of scarlet fever. Med. Press and Circular, July 12, 1876, p. 25.

8 **Stedman, C. E.**—Scarlatina complicated with typhlitis; fatal on the seventh day. Boston Med. and Surg. Jour., Dec. 28, 1876, p. 756.

9. **Gibney, V. P.**—Scarlatinal hæmaturia. Med. Record, Aug. 26, 1876, p. 551.

10. **Hall, F. DeH.**—Treatment of acute albuminuria. Practitioner, August, 1876, p. 101.

11. **Brakenridge, D. J.**—Objections to the use of salicylic acid in the treatment of scarlet fever. Med. Times and Gaz., Dec. 2, 1876, p. 621.

v. HUETTENBRENNER (2) relates a case in which the same patient was attacked with scarlet fever twice within the space of two months. For the diagnosis of such cases, he thinks it important that no symptom should be wanting, particularly the characteristic desquamation.

Olshausen (4) records five cases of scarlet fever occurring during the early days of the lying-in period, and refers to those of Clemens, Braxton Hicks, and various other writers. He thinks that the puerperal epidemics described during the last century by Hamilton, Hecquet, and Ludwig, under the names of febris miliaris, fièvre rouge or pourpre bleu, and miliaria rubra, were genuine scarlet fever. The epidemic described by Malfatti as having raged in the Vienna Lying-in Institute, during the winter of 1799–1800, seems to have given an impetus to the assumption that puerperal fever may appear under the guise of scarlet fever, since such outbreaks occurred in some instances in lying-in hospitals while no similar epidemic prevalence of scarlet fever was observed outside their walls; since the disease, at least in many epidemics, attacked the women, like puerperal fever, with great malignancy; since it was often complicated with peritonitis or other such localizations as occur in puerperal fever, whereas the angina was almost always very slight, or seemed altogether wanting; since, like puerperal septicæmia, it nearly always made its appearance during the first few days of the lying-in period; and since infection from scarlet fever very frequently could not be made out.

The author endeavors to show that these facts do not warrant the conclusion that a disease allied to, or identical with, septicæmia can assume, in lying-in women, the appearance of scarlet fever. He looks upon Clemens' cases, as well as those of Dance and Guéniot, and many of Braxton Hicks', particularly those in which the infection was traceable, or which coincided with a prevalence of scarlet fever in the neighborhood, as undoubted cases of genuine scarlet fever. His own cases were as follows:

A woman pregnant for the third time, who had already been in the Clinic four weeks, was easily delivered on the 3d of January, 1866. After two days' freedom from fever, there was some tenderness of the uterus and a rise of temperature (101.3° F.) Twelve hours later, on the third day, she had a chill, and the temperature was 105.8° F. The next day a scarlatinous rash was found extending over the whole body. Slight redness of the fauces, without pain on swallowing. The uterus remained tender for a short time longer, without, however, any exudation being discoverable, and without peritonitis. On the seventh day after labor the rash was fading, and desquamation began at once. A diarrhœa of several days' duration followed a dose of castor oil. By the eighth day the temperature had fallen to normal. Brain symptoms had not shown themselves, and there was no albuminuria. On her discharge, twenty-five days after labor, desquamation was still to be seen.

From lack of room, a primipara, delivered on the 17th of January, had to be placed near this woman, and fell ill on the fourth day of her lying-in. On the fifth day the temperature had risen to 104.72° F., with a pulse of 136. On the next morning the rash and the angina were present. The case progressed favorably in every respect. On the ninth day the rash had nearly disappeared. On

the tenth day desquamation began, with perfect absence of fever. No abdominal complications occurred.

The other *accouchées* escaped. Among the other inmates of the Clinic there were no diseases of any sort, and particularly, for a long time before and after this, no septic diseases. Where and when the first patient became infected, could not be ascertained. The second, of course, was infected from the first. Neither of them had ever had scarlet fever before.

Of the third case, which occurred in the Polyclinic, unfortunately, only a scanty account is given from memory, as the written data had been lost. A woman was seized with high fever and severe head-symptoms the day after labor. On the second day she was found comatose, with a scarlatinous rash covering the whole body. Nothing abnormal could be discovered about the abdominal organs. She died the same day.

A fourth case, likewise fatal, was observed in January, 1875. Mrs. C., a healthy woman, in good circumstances, had never had scarlet fever. She was delivered of her third child on the 27th of January, at 8 o'clock in the morning, so easily and rapidly that the midwife did not reach her until half an hour after the birth of the child, and simply removed the placenta by external pressure. No physician was present. On the evening of the next day (January 28) there was a moderately severe chill, with a temperature of 103.82° F. January 29, in the morning, the patient's face was of a deep red; pulse 140 and small; temperature 103° F.; skin moist; the uterus in its proper position, a little tender, which was not afterwards the case. In the evening the temperature was 104.9° F. The chest and the whole trunk now showed a deep-red, confluent rash; the throat and palate were markedly reddened and slightly swollen; no pain on swallowing; a good deal of mucus in the throat. On the next day temporary painfulness of deglutition was complained of; repeated vomiting, diarrhœa; bleeding from the nose. January 31, the temperature was 105.62° F. in the morning and 103.8° F. in the evening, with the pulse constantly at 140. The tongue had shed the white coat which covered it at first, and was now of a purple red, with enlarged papillæ. She was almost wholly sleepless, but with her mind clear, and no delirium. January 31 (p.m.), manifest, but not intense, jaundice was observed. Repeated vomiting; no albuminuria. The rash remained almost undiminished until death. It had assumed a livid, dusky, blue-red color, only somewhat tempered by the jaundice. On the limbs the rash was paler and in great part macular. On the seventh day the sensorium was attacked. There was great drowsiness, delirium, and unconscious excretion. In spite of energetic treatment with cold baths, quinine, and wine, death followed a seven days' illness, full eight days after delivery.

Examination of the abdominal cavity revealed a perfectly healthy condition of the genital organs; the uterine lymphatics free; and no peritonitis. The glomeruli of both kidneys were highly injected and partly destitute of epithelium; cortical portion

hyperæmic; interstitial tissue unaffected. Spleen somewhat enlarged, anæmic, and soft. Liver not icteric; its lobules easily recognizable. Icteric staining of the skin not present.

This case is interesting in several respects. For weeks before her labor the patient had not been out of doors, and certainly had not come in contact with scarlet fever patients. There was no epidemic in Halle at the time. Twenty-four hours after labor a severe, genuine scarlet fever appeared, which, as in most other recorded instances, was characterized by the intensity of the rash and the insignificance of the angina. With the pronounced exanthem, the absence of any symptoms suggestive of puerperal septicæmia, and the post-mortem appearances, there can have been no confounding of scarlet fever with a septic infection. Indeed, almost every possibility of septic infection was wanting, since the midwife did not arrive until after the birth, and had no other patients with puerperal disease at the time.

The fifth case is, briefly, as follows: Mrs. G., a primipara, 25 years old, was delivered with the forceps, by which an extensive laceration of the perinæum was produced, which was overlooked. By noon of the same day she had vomited several times, and had had no sleep. On the second day there was fever, and still no sleep. On the third day, in the morning, her temperature was 102.2° F., and her pulse 120. On my first visit, in the evening, I found the patient with a remarkably red face; temperature 104.54° F.; pulse 150; a tolerably well-marked raspberry-tongue; the fauces of an intense cherry-red and a little swollen. Some complaint was made of pain on swallowing. Almost the whole body was covered with a scarlatinous rash, most intense on the breast and abdomen. Her mind was perfectly clear. The perinæum was entirely ruptured, including a portion of the recto-vaginal septum. The edges of the wound were covered with a dirty coating, without any considerable swelling. This soon cleared off, and the wound cicatrized kindly.

The rash slowly faded away, ending in abundant desquamation. After the first day [? of the rash] the temperature fell from 101.3° to 102.38° F., with a persistent pulse-rate of 120. On the seventh day it rose again (to 103.64° F. in the evening). The cause appeared in a bilateral parotitis, which, in about eight days, advanced to suppuration on either side. The patient then slowly recovered. Consecutive albuminuria did not occur. There were no symptoms of endometritis or perimetritis.

Here, too, the source of the disease was obscure. There was no scarlet fever or puerperal disease in the village, as the physicians of the place assured me. We have here, then, the outbreak of the exanthem soon after labor, a moderate angina, and the rapid spread of the rash over the whole body.

The author considers that puerperal scarlet fever, whether in sporadic cases or in those occurring during an epidemic, whether its genuineness be undoubted or whether there be grounds for suspecting a dissimilar nature, shows, with very rare exceptions, the

following peculiarities: That it makes its appearance during the first week of lying in, and almost always within the first three days; the insignificance of the throat affection; and the rapid, almost lightning-like appearance of the rash over the whole body simultaneously, and often its deep, dusky red coloration.

Primiparæ, from their including a greater number of individuals who have never had scarlet fever, are more prone than multiparæ to suffer from the disease in childbed. Sixty two of the former, and forty two of the latter, were the subjects of the cases analyzed. The course of the disease is sometimes very light, and sometimes of the utmost severity, even proving fatal within the first 48 hours. In general, the mortality is high, three deaths having occurred among seven patients attacked during pregnancy, and 64 among 134 attacked during the lying in period. The mortality shows an inverse ratio to the time elapsing between delivery and the outset of the disease.

Diarrhœa is a common symptom, and one of unfavorable import. The lochia, the secretion of milk, and the involution of the uterus are wholly unaffected in the great majority of cases. In a few cases there is, at the beginning, moderate tenderness of the uterus, which soon disappears. Metrorrhagia has never been observed. In seven cases occurring during pregnancy, premature labor took place in four.

In the treatment, purgatives should be avoided. Stimulants are certainly advisable in severe cases. Above all, in case of persistent high fever, cool or cold baths should not be omitted.

Lehmann (5) details three cases of puerperal scarlet fever, which have come under his observation. In the main he agrees with Oldshausen's conclusions, but considers that abdominal inflammatory affections are not so rare as the latter supposes, and that they are not fortuitous complications, but directly due to the scarlatinous poison. He raises the question of whether there is any connection between scarlatinous nephritis and such secondary local affections, particularly those of the peritonæum.

Steiman (8) relates the case of a hospital interne who contracted scarlet fever for the second time, and who died with typhlitis set up by the presence in the appendix of a concretion, apparently not of recent formation. The scarlet fever was progressing most favorably when the peritonitis arose.

Gibney (9) records the case of a child, the subject of hip-joint disease, in whom the invasion of scarlet fever was accompanied by a sudden and abundant hæmaturia; and calls attention to the persistence of the hæmaturia for a period of four weeks, the absence of any marked constitutional disturbance other than an unusual degree of emaciation, the absence throughout the attack of any general or local œdema, and the influence of the intercurrent scarlet fever on the morbus coxarius.

Hall (10) gives the treatment which he employed in dispensary practice in an epidemic of about three hundred cases of scarlet fever. Directly any albumen was detected in the urine, the patient

was ordered the perchloride of iron, and was allowed no solid food except a little bread and milk, and as much water as he liked to drink; this treatment, together with keeping the skin gently acting, sufficed in the majority of cases, but in a certain number the urine was almost suppressed, and in some there were uræmic symptoms. In either case he forbade all food for twelve hours, the child to have nothing but water and a drink made of acid tartrate of potash (ʒ j. ad O. j.) in sweetened water with a little lemon-juice. If at the end of this time the kidneys were beginning to act, he allowed a little milk, but not more than a pint in the twenty-four hours; if, however, the uræmia continued, with little or no urinary secretion, he persevered with the water and bitartrate of potash, and in severe cases nothing else was given for thirty-six hours. Dry cupping, mustard poultices over the loins, and a purgative were the only additional remedies employed.

Brakenridge (11) remarks that salicylic acid, judging *à priori*, should prove to be "almost an ideal remedy" against scarlet fever, but his experience with it in nine cases leads him to warn the profession that it is apt, apparently, to give rise to unpleasant results, increasing the frequency and duration of albuminuria, causing delirium, etc.

12. **Bell, R.**—Small-pox. Brit. Med. Jour., Nov. 25, 1876, p. 677.

13. **Svanowsky, N.**—Parasitic nodes in the lungs in small-pox. (*Die parasitären Knoten in den Lungen bei Variola.*) Centralbl. f. d. Med. Wissensch., Nov. 4, 1876, p. 788.

14. **Wilkinson, W. H. W.**—The small-pox outbreak in Islington. Lancet, Oct. 14, 1876, p. 541.

15. **Hutchinson, C. F.**—Modified small-pox and chicken-pox. Brit. Med. Jour., Sept. 16, 1876, p. 362.

16. **Irvine, J. P.**—Cases illustrating the occasional obscurity of the acute specific diseases. II.—Case of varioloid. Med. Times & Gaz., Oct. 14, 1876, p. 434.

17. **Orchard, T. N.**—On the immunity from small-pox secured by revaccination. Lancet, Nov. 25, 1876, p. 746.

18. **Adams, Z. B.**—Unfortunate result of vaccination. Boston Med. & Surg. Jour., Dec. 21, 1876, p. 722.

19. **Warlomont.**—Animal vaccination. Med. Press & Circular, July 19 and 26, 1876, pp. 46 and 68.

20. **Mackenzie, S.**—Vaccination with glycerined lymph. Lancet, Nov. 4, 1876, p. 636.

21. **Shortt, J.**—Description of a needle-vaccinator. Lancet, Nov. 11, 1876, p. 677.

Adams (18) vaccinated three children twice unsuccessfully with animal vaccine. He then vaccinated them a third time with humanized vaccine. In one of these children the vaccination ran its regular course up to the 14th day, when marked symptoms of purulent infection were observed. Deep, black sloughs occupied the

site of the vaccine vesicles; there was brawny hardness of the whole deltoid region, a huge diffuse abscess reached from the axilla to the lower border of the ribs, with hard infiltration extending to the sternum in front, and below the scapula behind, showing a waxy whiteness with distended veins. A thin ichor flowed from large incisions, and no pus. This child died of pyæmia on the 21st day. There was no autopsy.

Another of the three children went through the disease normally, but a second vaccination from its own arm (Bryce's test) on the seventh day succeeded. The operation failed on the third child, and was repeated with lymph from the arm of the second, the result being three large, unhealthy, irregular sores, with no clear lymph, but some yellow pus, deep induration of the whole deltoid region, and tenderness and enlargement of sub-axillary glands. This child had a somewhat scrofulous look, and its mother was phthisical. A fourth child, vaccinated from the one which afterwards died, developed similar complications.

22. **Schwimmer, E.**—Salicylic acid in the treatment of the acute exanthemata. (*Ueber den Heilwerth der Salicylsäure bei akuten Exanthemen.*) Wien. Med. Wochenschr., Aug. 12, 19 and 26, and Sept. 2, 1876, pp. 819, 835, 859, and 883.

23. **Hamilton, A. McL.**—Upon certain neuroses following the zymotic fevers. Med. Record, Oct. 28, 1876, p. 696.

INFLAMMATIONS; ACUTE AND NON-CONTAGIOUS.

JAMES C. WHITE, M. D.

1. **Hensley, Philip J.**—A case of erythema nodosum; with diagram of temperature. St. Barthol. Hosp. Rep., Vol. XI., 1875, p. 250.

2. **Paspelow.**—Erythema nodosum of the buccal mucous membrane. Centralblatt f. d. Med. Wissenschaften, March 17, 1877.

3. **Ory.**—Traitement de l'érythéme. La France Médical, Oct. 25, 1876.

4. **Soltsien.—Uffelmann.**—Erythema papulatum and nodosum. Centralb. fur die Med. Wissensch., Jan. 27, 1877.

5. **Uffelmann.**—Ueber die cumbose Form des Erythema nodosum. Deutsches Archiv. für Klin. Med. Bd. xv.ii., H. 2 & 3.

6. **Laserre, Jules.**—Essay on the etiological conditions and pathology of urticaria. Paris. Parent., 1877 (Le Mouvement Méd., p. 201, March 31, 1877).

7. ——— Urticaria following the sting of a wasp in the œsophagus. London Medical Record, Feb. 15, 1877.

8. **Milton J. L.**—On giant urticaria. Edinburgh Med. Journal, p. 513, Dec., 1876.

9. **Nitsche.**—Treatment of burns by salicylic acid. Tagblatt der Versammlung Deutscher Naturforscher und Aezta in Graz., 1875.

10. ——— Dressing for burns. Peninsular Journal of Medicine, p. 729, Nov., 1876.

11. **Ponfick.**—On death after extensive severe burns. Berlin Klin. Woch., No. 17, 1876. (Med.-Chir. Centralbl., 1876 (N. Y. Med. Jour., p. 548, May, 1877).

12. **Riddell, S. S.**—Chloral hydrate in burns and scalds. Phil. Med. & Surg. Reporter, p. 5, Jan. 6, 1877.

13. **Alexander, R. M.**—Muriated tincture of iron as an antiseptic in erysipelas. Louisville Med. News, p. 207, May 5, 1877.

14. **Bellieu, E.**—Experimental researches on traumatic erysipelas. Journal de Med. de Moscow, No. 13, 1876. Centralb. f. Chirurg., No. 21, 1876. (Rev. des Sciences Méd., p. 93, Jan., 1877.)

15. **Behier.**—Erysipelas as a sequela of epithelioma. L'Union Méd., et 3 Juin, 1876.

16. **Cavazanni.**—Camphorated ether in erysipelas. London Medical Record, Nov. 15, 1876.

17. **Chase, W. B.**—Erysipelas and puerperal fever. Med. Record, p. 30, Jan. 13, 1877.

18. **Culbertson, H.**—Is diphtheria a form of erysipelas. Ohio Med. Reporter, p. 289, Dec., 1876.

19. **Depres, M. A.**—Treatment of erysipelas. La France Méd., p. 496, Oct. 25, 1876.

20. **Galezowski.**—Ocular alterations in erysipelas of the face. Recueil d'Opthal. July 1876. (La France Méd., p. 648, Oct. 4, 1876.)

21. **Hug.**—Impfrothlauf in der Stadt Freising. Intelligenzb., 49, 1875.

22. **Macias, R.**—Abortive treatment of erysipelas by quinine and opium. (Remarks on F. L. Satterlee's paper.) Anales de la Association Larrey, p. 149, Sept. 1, 1876.

23. **Matthews.**—The muriated tincture of iron a "Specific" for erysipelas. The Med. and Surg. Reporter, Feb. 24, 1877.

24. **Ory, E.**—Treatment of erysipelas. La France Méd., p. 680, Oct. 18, 1876.

25. **Oswald, J. W. J.**—Liquor ferri perchloridi fortior as a local application in erysipelas. Brit. Med. Jour., Dec. 30, 1876.

26. **Putney.**—The treatment of erysipelas and carbuncle. The Med. & Surg. Reporter, April 7, 1877.

27. **Sigaud.**—Study of albuminuria in erysipelas and lymphangitis. Thèse de Paris, No. 430, 1876. (Gaz. des Hôpit., p. 78, Jan. 25, 1877).

28. **Tinneane.**—Erysipelatous metritis, the mutual relations of erysipelas, scarlatina, and the puerperal process. Dublin Journal, April, 1877.

29. **White, L.**—Liquor ferri perchloride fortior as a local application in erysipelas. British Med. Journal, Dec. 9, 1876.

30. **Gibbons, Henry.**—An epidemic of boils. Pacific Med. & Surg. Jour. (The Med. and Surg. Reporter, March 31, 1877.)

31. **Ory.**—Traitement des furoncles. La France Médicale. Dec. 13, 1876.

32. **Roth, J.**—Note concerning furuncles and anthrax, their abortive treatment. Rev. de Therap. Médico-Chirurg. (L'Union Méd. du Canada, p. 55, Dec., 1876.)

33. **Chavanis.**—(Lyon Médical, 31 Dec., 1876.) From Lond. Med. Record, April 6, 1877.

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35. **Delon.**—Treatment of anthrax by cauterization. Thèse de Paris, Dec. 24, 1876. (Gaz. des Hôp., Feb. 27, 1877.)

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M. CHAVANIS (33), in reference to a case of anthrax in which he employed excision and cauterization with chloride of zinc paste, and subsequent injections of carbolic acid, and salycilic acid internally, notes that on the whole carbolic acid does not seem to him to fulfil all its therapeutical promise. Three cases of Raimbert's, one of Lezart's, and his one are favorable to the use of antiseptics; but it is not on so small a number of cases, in which the cure may be due to cauterization as much as to antiseptics, that a new treatment can be based. Cauterization is necessary. Carboli acid may also be employed as an adjuvant, in subcutaneous injections, compresses on the œdema, and also internally, without the pretension of being a specific against anthrax. In all respects iodine seems preferable.

DR. DELON (35) describes four cases of anthrax cured by cauterization in the wards of Dr. Depres. He made a crucial incision down to the bottom of the slough. He then separated the lips of the wound and stuffed its bottom with small pellets of tinder which had been steeped in a solution of eighteen parts of chloride of zinc to fifteen of water. If the slough were too deep to allow the caustic to be easily carried to the bottom, he cut out the four fragments which allowed him greater facility of action. The caustic was allowed to remain twenty-four hours, covered with a poultice to subdue the inflammation. It was then taken away to allow the permanent application of emollients, if the cautery seemed to be effectual, if not, a fresh cauterization is performed. Delors has also observed that the temperature rises in proportion as the affection develops, and falls when the disorder is arrested.

GUERIN (37) applies a large blister to the affected surface with a hole in the centre, through which carbolic acid and other disinfectants are introduced to the centre of the carbuncle.

RAIMBERT (39) arrives at the following conclusions:—Cauterization of a fresh carbuncle is rational, because it destroys the bacteria, which may be supposed to be in the skin, and especially in the circumscribed scab. As long as the poison is limited to the skin and subcutaneous connective tissue, we may hope to neutralize it by the subcutaneous injection of antiseptic solutions, which must be made in sufficient numbers in appropriate positions. If the poison has been absorbed into the blood, subcutaneous injections are no longer capable of destroying it, and M. Raimbert considers intravenous injections as too dangerous a proceeding to be adopted.

DR. SCHNEIDER (40) makes use of perchloride of iron in preference to blisters or cauterizations, and claims for it the following advantages: It obliterates the divided vessels and causes contraction of the traumatic surface, thus diminishing the chances of septic absorption. It plays the part of an antiputrescent and disinfectant. It mummifies the slough and renders it inoffensive, decomposes deleterious gases, combines with exudations to form a brown and imputrescent crust. It does not destroy the healthy tissues, nor produce any loss of substance. He incises deeply and widely, filling the cavity with lint dipped in perchloride of iron. After 24 or 48 hours the dressings are readily removed and display healthy tissue, which speedily cicatrizes.

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DR. FOX (42) communicates an abstract of the special report of Drs. Lewis and Cunningham, recently made to the government of India upon this affection, which has been the subject of such diverse expression of opinion lately. They affirm that it is neither a parasitic affection, scrofula, nor syphilis, but that it is a peculiar phase of lupus, for which they propose the name lupus endemicus. From this conclusion Fox dissents. He regards it as an affection *sui generis*, having furunculoid affinities, and running an indolent course in consequence of a depraved state of the health.

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anodyne amyl colloid. British Med. Jour., Dec. 30, 1876. (The Practitioner, p. 130, Feb., 1877.)

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55. **Jalaguier.**—Neuralgic herpes pudendorum. Gaz. des Hôpit., 11, 20, 1876.

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58. **Tucker, J. I.**—A case of herpes zoster frontalis. Journal of Mental and Nervous Diseases, p. 161, Oct., 1876.

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In the case of Zona of Perroud (57), the patient entered Hotel Dieu on account of phthisis, for which small doses of arsenic were given. The vesicular efflorescence of herpes was developed in groups situated upon the left side of the perineum and margin of the anus, upon the internal and posterior upper fifth of the thigh, and upon the left surface of the penis and scrotum. The eruption was preceded by acute neuralgic pain in these regions. Dr. Perroud does not think that the zoster was produced by the arsenic.

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Dohrn (63) relates the case of a midwife who, during the period from March 25th to July 13th, presided at the birth of 65 children. Of these, 28 sickened with pemphigus, mostly within the first two weeks after birth, and eight died. In accordance with advice, she abstained from practice, and left town for a month. From August 13th to September 3d, nine children were born under her ministrations, of whom three contracted pemphigus. These all recovered. She again gave up practice, resuming it on the 1st of October. Between the 1st and the 11th of October, of six children born, three were attacked with pemphigus, one of whom died. She then gave up her practice for the third time.

II.

SYPHILIS AND VENEREAL DISEASES.

GENERAL QUESTIONS IN SYPHILIS, THERAPEUSIS, ETC.*

R. W. TAYLOR, M. D.

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8. **Colomiatti.**—Contribution to the pathological histology of constitutional syphilis, and to the study of the genesis of giant cells. Giorn. Ital. delle Mal. Ven. e della Pelle, No. 5, 1876.

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PROPHYLAXIS OF SYPHILIS AND PROSTITUTION.

133. **Black, J. R.**—Preventing the extension of syphilis. Cincinnati Lancet and Observer, Dec., 1876.

134. **Bouchard.**—Hygiene and prophylaxis of venereal diseases. Lectures. Gazette Hebdom. de Med. et de Chirur., Nos. 29, 30, 34, 36, 37, 39 and 40.

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137. **Drysdale, C. R.**—On the prevention of syphilis. Med. Press and Circular, Oct. 18, 1876.

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140. **Ferssmann, D.**—Prostitution in Helsingfors. Finska Läk. Sällsk. Handl., xvi., p. 173, 1875. (Hirsch's Jahresbericht, No. 2, p. 539. 1876.)

141. **Gamberini, P.**—Report on prostitution in Bologna. Giorn. Ital. delle Mal. Ven. e della Pelle, No. 2, 1876.

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143. **Jeannel, J.**—Prostitution in England. Annales d'Hygiene. April, 1875.

144. **Lowndes, Fred. W.**—The working of the Contagious Diseases Acts at Aldershot, Chatham, Windsor, Plymouth, Devonport, and Stonehouse. Med. Times and Gaz., Jan. 22, 1876.

145. **Lowndes, F. W.**—The extension of the Contagious Diseases Acts to Liverpool and other seaports practically considered. Brochure, Liverpool, 1876.

146. **Lecour, C. J.**—The actual state of prostitution in Paris. Brochure, Paris, 1874.

147. **Mireur, H.**—Syphilis and prostitution in their relation to hygiene, morals and law. Paris, 1875.

148. **Nevins, J. B.**—Inquiry into the condition of prostitution and alleged influence of the Contagious Diseases Acts. Liverpool, 1876.

149. **Nevins, J. B.**—Statement of the grounds upon which the Contagious Diseases Acts are opposed. Brochure, London, 1875.

150. **Pini, G.**—Laws upon prostitution. Giorn. Ital. delle Mal. Ven. e della Pelle, No. 2, 1876.

151. **Poray, Koschitz.**—Instance of the spread of syphilis in a workshop. Sitzungbr. der Med. Gesellsch. zer Charchow., 1875. Centralbl. f. Chirurg. (Rundschau, May, 1876, p. 412.)

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153. **Sims, J. M.**—Prevention of syphilis. Address before Am. Med. Association. Trans. Amer. Med. Association, 1876. (Med. and Surg. Reporter, July 15, 1876.)

154. **Strohl, E.**—The question of prostitution. Viertelj. f. Gerichtl. Med. N. F., xxiv., Jan., 1876.

155. **Schpeck, E.**—Statistical researches in syphilis in the female population of St. Petersburgh. Translated by Poray Koschitz and Ch. Schwartz. Annales d'Hygiene Publique et Méd. Legale, 2 Series, Tome XLIV., 1875.

156. **Schpeck, E.**—Statistics in reference to the bodily state of prostitutes. St. Petersburgh Med Zeitschrift, 1875.

157. **Valle, E.**—Prostitution and syphilis. (*La prostitutione e la sifilide*) Brochure, 1876.

158. **Anonymous.**—The limitations of syphilitis. The Med. and Surg. Reporter, Jan. 6, 1877.

159. **Anonymous.**—Compulsory medication of prostitutes by the State. Westminster Review, July, 1876.

160. Tables relative to the working of the Contagious Diseases Acts as regards the army, comparing the results obtained from the returns of twenty-eight stations in the United Kingdom. Government Document, 1875.

161. English and Continental laws and regulations concerning prostitution. (Pamphlet without name, date, etc.)

162. Army Medical Department report for the year 1874, Vol. XVI., 1876.

CONGENITAL AND INFANTILE SYPHILIS.

JAMES NEVINS HYDE, M.D.

1. **Appai, C.**—The transmission of syphilis between nurses and nurslings, and its medico-legal aspects. Giorn. Ital. d. Mal. Ven. e. della Pelle, Aug, 1876, p. 237. (Rundschau, Feb. 1877, p. 117.)

2. **Cory, Rob't.**—Origin of infantile syphilis. London Lancet, June 17, 1876.

3. **Diday, M. P.**—Syphilis by conception. Annales de Dermat. et de Syphilig. Tome VIII., No. 3, p. 161.

4. **Dowling, Francis O.**—What influence does a syphilitic father exert upon his offspring? Cincinnati Lan. and Obs., V. 38, May 1877, p. 453.

5. **Ercolani.**—Syphilitic disease of the placenta. Annales de Tocologie, July 1876. (Monthly Abstract of Med. Sci., Dec., 1876, p. 572.)

6. **Gallois.**—Examination of the question respecting the innocuity of the milk of syphilitic nurses. Paris, Delahaye et Cie, 1877.

7. **Hutchinson, J.**—On Colles' law, and on the communication of syphilis from the fœtus to the mother. Med. Times and Gazette, Dec. 9, 1876.

8. **Hutchinson, J.**—Illustrations of Clinical Surgery. Vaccination syphilis. Phila. Lindsay and Blakiston, 1877.

9. **Kassowitz, M.**—The hereditary transmission of syphilis. (Translation of Dr. M. A. Wilson,) N. Y. Med. Jour., Feb. (et seq.) 1877, p. 162.

10. On Colles' Law of immunity from syphilis. Editor of the Med. and Surg. Reporter, Jan. 20, 1877, whole No. 1038, p. 64.

11. **Sensency, B. R.**—Vaccino syphilis. Paper read before the Surgical Section of the American Medical Association, in Chicago, Ill., June 7, 1877. Trans. Am. Med. Assn. for 1877.

12. **Voss, R.**—Inoculation of syphilis by the milk. St. Petersburgh Med. Wochenschr., No. 23, 1876; Centralbl., No. 44, 1876; (Dublin Jour. of Med. Sci., Jan., 1877; Lyon Médic., Feb. 18, 1877, p. 247.)

APPAT (1) very properly insists that the sole basis for the solution of medico-legal questions arising in consequence of the transmission of syphilis between nurses and nurslings, is to be found in the careful study of all the pathological facts. Beginning therefore with a brief historical sketch of the investigations upon the subject of hereditary syphilis, the author fully describes the principal manifestations of the disease, classifying the cutaneous lesions under the eight varieties given by Fournier, and proceeding to a delineation of the mammary ulcer. The site of the latter is, most commonly, in the order of decreasing frequency; the base of the nipple, the nipple itself, the areola and the mammary globe. Multiplicity of lesions means numerous, simultaneous or successive inoculations, from repeated applications of an infected child to the breast. The lesion is either erosive or pustulo-crusticeous; the former, of those still suckling infants, the latter, of those who have ceased to give the breast.

In a medico-legal investigation, the duty of the physician is, first, to gather the facts relating to the history of the child, the symptoms exhibited before death, or if the child is living, the sequelæ of such symptoms. No hypothesis can be substituted for the possession of such facts, and if the latter are contradictory, or not established, such circumstance should be noted. Next comes the objective examination of the child, if it be living, with a view to the discovery of disease-relics in the event of a previous cure or successful treatment; in the case of a child still affected, the truth can be attained much more readily and certainly. Last in order is the examination of the nurse, which should be as complete as possible, not merely to discover the nature of the disease, but also, if possible, its origin. The author is disposed to attribute

much importance to the site of any existing adenopathy, especially if the glands of the axillæ are found to be involved, where often the medical jurist will find "a page which is eloquent in its tale of truth."

Dr. Cory (2), believing that the immunity from syphilis of a mother bearing an infected child, is as yet unproven, presents an ingenious hypothesis to explain the transmission of the disease from the mother to the child, when the latter is apparently healthy at birth and is subsequently attacked. He supposes that, at the moment of the separation of the placenta, and before the cessation of the fœtal circulation, some of the maternal blood is swept into the umbilical vein and blood infection results. Hence early grave hepatic involvement. How is the mother infected if not then by the fœtus? He supposes that in prior pregnancy she has been infected by an ovum impregnated with a diseased spermatazoon, with the result of early abortion, so early perhaps as only to induce "retarded menstruation." Ultimately, the combination of two healthy elements may produce a sound fœtus. It seems to him incredible that a child, the offspring of a diseased first element, should be born apparently well, and yet should have previously transmitted to its parent a disease of which it displays no symptoms.

He calls attention to this difference between hereditary syphilis and other hereditary diseases, viz.: that in the former the disease is fostered and built up in the growing embryo, is present, inevitable and strictly inherited; while in the latter, there is merely a greater liability to the influence of external noxious agencies. One is a disease *in esse;* the other, *in posse.*

We have heretofore (*Archives of Dermatology*, Vol. III., No. II., p. 180) briefly noticed the paper which Diday (3) here presents in full. It is written in the well-known characteristic style of the author, and attempts to establish clinically and logically the theory that the product of conception, infected by the father, may transmit the disease to the previously healthy mother during intra-uterine life. This is the theory of "*Choc-en-retour*"—a theory conspicuously at variance with the proposition of Kassowitz, that intra-uterine infection is impossible so long as syphilis demands a virus-bearing element for its common carrier. It may be remarked that Diday brings his best powers to bear upon the task. Twenty-six cases are tabulated—the greater part of them from his personal observation, and in connection with each is given, (a) the duration of cohabitation preceding the pregnancy; (b) the condition of the husband at the moment of conception; (c) the period of pregnancy at which maternal syphilis developed, with (d) the nature of her symptoms; and (e) the issue of the product of conception. Two other cases are added, in which the maternal syphilis developed only after pregnancy had been completed. His objections to accepting, in explanation of these latter phenomena, the occurrence of ordinary infection (wife directly from husband) are: (1), such a supposition would require sexual congress to have been effected at, or near, the date

of accouchement, when the husband would be naturally disinclined to the act; (2), the accoucheur would have detected the chancre. These reasons will simply pass for what they are worth. He urges for the former cases, (1) the absence of initial chancre, (2) the simultaneous development, at several points on the body of the mother, of a non ulcerative syphilide, type of the first eruption of the secondary stage of syphilis; (3) the average interval preceding this explosion (between the 65th and 70th day after conception); (4) the non-contagious character of the lesions of the infected father at the date of conception ("acne" of the head, palmar syphilide, &c.), and, (5) the prior immunity of the wife after cohabitation with an infected husband for a variable period of time.

He calls attention to the precocity of the maternal symptoms in the cases where the children only exhibited the disease from 15 to 30 days after birth.

Not content, however, with his somewhat enforced deductions from these premises, the author pushes his conclusions still further, holding that the ovule itself is a germ of contagion *ab origine*, and explains with Cory the syphilization of some mothers, by supposing a previous pregnancy, lasting for but a month or less, and making itself known merely by a menstrual epoch somewhat more painful than others, and accompanied by the ejection of a few blood clots.

Admitting the rarity of this syphilization "d'emblée," Drouy says that the question of interest is not the manner in which syphilis by conception occurs, but rather, why do so many mothers enjoy an apparent immunity? Here he adduces the law of Colles, and would have it believed that the fœtus may exercise a varying degree of influence upon the mother, in one instance infecting her with its disease, in another endowing her with a mysterious gift of immunity. And the causes of this variability the author proposes to investigate in the future.

Dowling's paper (4) sets forth briefly the conflicting views of authors upon the subject of the transmissibility of syphilis from parent to child, the chief imperfection of which lies in the fact that the opinions of the latest and best writers upon the subject are ignored. He believes that when the father is affected with either primary or secondary syphilis, mother and child will almost certainly contract the disease—the mother through the medium of her offspring—and that in cases where the syphilis of the father wanes, either from lapse of time or treatment, the child will be affected and the wife escape. On the other hand, in tertiary disease of the father, "the infection of either wife or offspring need not be feared," the male parent transmitting a constitutional diathesis which renders the child peculiarly susceptible to the influence of other diseases, notably scrofuloid affections, which are distinguishable from scrofula. It is to be remarked that in discussing propositions of the character of those stated, the weight of authority will often be found opposed to their acceptance; and much more rigorous deduction is necessary for their establishment than that offered by the author.

The cases presented by Mr. Hutchinson (8) in this fasciculus (twenty-four in number) have appeared in part in the Transactions of the Royal Medical and Chirurgical Society. The plates are very well executed, and will serve a good purpose in enforcing the two lessons inculcated in the forcible language of the text: first, the danger of vaccination from the arm of a syphilitic infant; and, second, the means to be employed to avoid that danger. The clinical results of vaccination-syphilis here portrayed are in agreement with what has been already accepted. It is well understood by syphilographers (*a*) that the syphilitic infant as a vaccinifer may be in a condition of apparent good health; (*b*) that the vaccine vesicle in cases where syphilis has been also communicated, may progress normally to its final phase; (*c*) that after the typical incubative period, the primary syphilis lesion may appear as an indurated, red, glossy tubercle, which will probably degenerate to an ulcer with scanty secretion and hard base and edges; and (*d*) that tissue or blood elements are essential carriers of the syphilis from arm to arm, and not the vaccine lymph.

The excellent translation of Kassowitz' monograph (9) places the observations of the author before the English reading members of the profession, in admirable form. A brief summary of the original has heretofore been incorporated with this digest of literature.

The Editor of the Medical and Surgical Reporter (10) enunciates the law of Colles, and quotes Mr. Hutchinson's recent remarks, laying before the profession in America the inquiries formulated in the late address before the Hunterian Society of London. He suggests that the deductions from Colles' law, point to the possibility of discovering a method of inoculation by which the virus of syphilis may be neutralized, and complete protection be afforded against it.

Senseney (11) enlarges upon the circumstance that the wise forethought of Jenner led him to anticipate the fact that the act of vaccination might, under certain circumstances, lead to the introduction of another morbid product than that intended, into the system. Taking this as his text, the author proceeds to give a hasty review of the subject of vaccino-syphilis, and the epidemics thus occasioned, giving to Dr. Joseph Jones, of Nashville, Dr. James Bolton, of Richmond, and Dr. Thos. F. Wood, of Wilmington, the credit of fully presenting the subject to the American public. There are no original observations of the author, the chief part of the paper allotted to the subject proper, being merely an exposition of the cases illustrated in Mr. Hutchinson's plates of vaccination syphilis recently issued.

Voss (12) inoculated three prostitutes with the milk of a woman affected with papular syphilis, who suffered also from moist mucous papules of the anal and genital regions, the mammary glands being free from disease. A syringeful of milk expressed from one breast was injected into the tissues of each prostitute by means of a Pravaz syringe. One who had been previously syphilitic suffered

no inconvenience. The second had urethritis, and was not affected. The third was a young girl sixteen years old, free from syphilis, who was injected on the eleventh day after her admission to the hospital. The inflammation and local suppuration excited, subsided in one week, but forty days after the inoculation, papules were developed around the site of the inoculation, and in five days maculo-papular syphilides appeared over the body with concomitant adenopathy, these symptoms disappearing under the influence of mercurial inunction.

13. **Barlow, T.**—Gummata in cranial nerves and changes in vessels in congenital syphilis. Path. Soc. London Lancet, p. 645, May 5, 1877.

14. **Barlow, T.**—Phlegmonous syphilides. Lancet, Jan., 1877, p. 26 (Am. reprint).

15. **Barraclough, G.**—On hereditary syphilis and the contagious diseases act. Med. Times and Gazette, Sept. 23, 1876, p. 349.

16. **Berger.**—Congenital syphilis. Report to the Société Medic. du VIe. Arrondissement. Gazette Obstét., Jan. 5, 1877, An. 6., No. 1, p. 13.

17. **Carre.**—On the keratitis of Hutchinson. La France Médic., Nos. 13, 14, and 15, Feb. 14, 17, and 21; 1877, pp. 98, 106, and 115.

18. **Drysdale, Chas. R.**—Observations on hereditary syphilis. The Doctor, Feb. 1, 1877, p. 39.

19. **Faure.**—Syphilis of new-born children. Gazette des Hôpit., p. 332, April 12, 1877.

20. **Fournier, A.**—Syphilitic nurses and nurslings. L'Union Médic., Nos. 52 and 58, May 5 and 19, 1877, pp. 733 and 805. (*à suivre.*)

21. **Guerin, A.**—Suspected vaccinal syphilis. L'Union Médic., No. 158, Nov. 23, 1876, p. 793.

22. **Guntz, J. E.**—Six cases in which fathers affected with so-called latent syphilis, produced children who were and remained healthy, the fathers afterwards exhibiting fresh symptoms of syphilis, without re-infection. Vierteljahrschft. f. Derm. u. Syph., 1876, Hft. 10, p. 526.

23. **Howard, Warrington.**—Epiphyseal disease from a case of inherited syphilis. Path. Soc. of London, Lancet, May 5, 1877, p. 646.

24. **Hutchinson, J.**—Clinical remarks on a case of deafness in connection with heredito-syphilis. Med. Times and Gazette, Jan. 16, 1875.

25. **Hutchinson, J.**—The types of syphilitic teeth. Half Yearly Compend. of Med. Sci., Jan., 1877.

26. **Infantile Syphilis.**—Case. Reports from Bellevue Hospital, N. Y. N. Y. Med. Record, No. 337, April 21, 1877, p. 246.

27. **Jacob, E. H.**—Hemiplegia from inherited syphilis. Case

treated in the Leeds General Infirmary. Med. Times and Gazette, No. 1399, Vol. I., 1877, p. 418.

28. **Mason, Osgood.**—Cases bearing on some doubtful points in the history of syphilis. N. Y. Med. Record, No. 316, Nov. 25, 1876, p. 761. Southern Med. Record, Mar. 20, 1877, Vol. VII., No. 3, p. 60.

29. **Monti, Alois.**—Clinical lecture on hereditary and congenital syphilis. Report Phil. Med. Times, No. 246, Vol. VII., p. 337.

30. **Parrot.**—Clinical lecture on Diseases of Children. Hereditary syphilis. Le Progrès Médic., No. 19, May 12, 1877, p. 365.

31. **Review of The Debate on Visceral Syphilis** at the Pathological Society of London. The Doctor, April 1, 1877. Vol. IV., No. 7, p. 82.

32. **Taylor, Frederick.**—On phlegmonous syphilides. London Lancet, April, 1877, p. 176. (Am. reprint.)

33. **Visceral Syphilis.**—Editor of the N. Y. Med. Record, Feb. 24, 1877, No. 329, p. 121.

34. **Zeissl.**—Late hereditary syphilis. Centralbl. f. d. Med. Wissen., April 21, 1877.

Barlow (14) reports the case of a boy, ten weeks old, who had snuffles, desquamation, mouth lesions and maculæ of the trunk. On the temporal regions, upper lip, front and back of the belly and thorax, thighs and dorsal surface of the right big toe, were numerous marble-sized, subcutaneous furuncles, without red areolæ, containing laudable pus and having no "core." On the nates were fluctuating tumors as large as a chestnut; clean cut ulcerations had been the sequelæ in two places. There was also adenopathy, with hepatic and splenic enlargement, and great debility. A cure was effected under the administration of mercury internally, and cod-liver oil locally. These were more acute lesions than the "Scrofulides phlegmoneuses" of Hardy; also no nodular masses could be discerned as in gummata, though (as stated) ulceration occurred in ten places. Hence the name prefixed to the article.

Berger (16) reported the case of an infant, two months old, presenting two small fluctuating tumors in the sheaths of the extensor tendons on the dorsal aspect of the right hand, at the metacarpo-phalangeal articulation and the wrist. These were succeeded by mucous patches of the throat, tonsils and fauces, which yielded to mercurial treatment, and were followed by a general eruption of pemphigus. Finally, papular syphilides appeared on the verge of the anus. The reporter called attention to the peculiar sequence of symptoms of the different stages of syphilis—a sequence occasionally noted in acquired syphilis.

Carre (17), after enumerating the symptoms of interstitial keratitis described by Hutchinson as occasioned by hereditary syphilis, including lesions of the choroid, teeth, tympanum (Davidson), lips, laryngeal and nasal passages, proceeds to describe the reaction apparent in the writings of such Continental authors as Mooren, Panas, Dolbeau, Perrin and Beau, who pronounce either

against the connection between the ocular and dental lesions or against their syphilitic origin. He names Giraud-Teulon and Démarquay, as accepting the views of the English school.

Carré announces the interesting fact, that 24 of Hutchinson's 64 observations had lesions of the iris; and legitimately concludes that in many of the others iritic symptoms may have been obscured by corneal opacities. *A priori*, the well-known aptitude of the iris for the display of syphilitic localizations, would lead to a suspicion of frequent iritic involvement in syphilitic keratitis; and it is suggested that this may form an important element in deciding questions as to the ethology in certain cases. Carré, however, is in error when he announces that the English author does not claim that he can diagnosticate hereditary syphilis by the teeth alone; for Hutchinson has recently declared that by some teeth he "would swear." This series of articles chiefly concerns the case of a child 13 years old, affected with hereditary syphilis, and exhibiting lesions of the cornea, teeth and tympanum. There was also iritis, which went on to complete annular posterior synechia of the left side, for which iridectomy was advised but not permitted—the disease of the eye becoming with severity of unusual degree.

Dr. Devenport's (18) observations are founded upon two cases of hereditary syphilis which he reports. In the first, there was a well-marked history of syphilis in a woman aged 36 years, where keratitis did not supervene till the age of 30. A mother had disease of the eye at 16, and a sister at 22. The father possibly died from syphilis of the brain, and the mother lost eight of eleven children. In the second case, an infant aged four months had syphilodermata, snuffles and anal mucous tubercles. The mother, aged 32, was suckling this her third child, the two former having died a week or so after birth. She had not a symptom of syphilis, and had always enjoyed excellent health. The husband was dissipated, and had had, as reported, disease of the bones.

This leads the author to admit that he had for some years been a convert to the theory of Cullerier, believing, as he did, that if it were at all common for the male parent to contaminate his offspring without the mother becoming affected, hereditary syphilis would become much more frequent than it actually is.

But he is reminded by the writings of Kassowitz, of Vienna, and R. W. Taylor, of New York, that he has certainly seen not a few cases in which there was really *no* valid evidence *whatever* obtainable, that the mother of the hereditarily syphilitic infant had *in any way* suffered from the disease. (The italics are his.)

Still he finds difficulty in accepting the views of the writers named, and thinks in practice it is well to remember that Cullerier's law is a very near approximation to the truth, maternal syphilis being often an insignificant disease and one readily overlooked.

He concludes by admitting that it seems quite possible that fathers may transmit syphilis to their offspring without affecting the mother, but that numerous fallacies have to be taken into account in statistics like those of Kassowitz, drawn from public charities and not controlled by the most careful observations.

Faure (19) happened to inspect an infant brought to a nurse in order to relieve her distended breasts. The child was found to be manifestly syphilitic, and due precautions having been taken, infection did not result. But the author takes occasion to point out the possible consequences to others from the single application to the breast of an infant thus affected.

Fournier (20) admirably delineates the line of conduct to be pursued by the conscientious practitioner, confronted with a syphilitic child at the breast of a nurse, who (a) as yet has not contracted the disease from it; or (b) has already become infected. The problems are studied both from their bearing on the present and future, not only in cases where the nurse refuses to discharge her duty further, and demands pecuniary indemnification for damage, but also when she persists, in her ignorance, to suckle the child. We have heretofore presented a full abstract of this lecture from a clinical report.

Guerin (21) presented to the Academy of Medicine a little patient who had been vaccinated nine days after birth—seven weeks prior to date. The immediate results of the vaccination had been quite normal, the vesico-pustules becoming well developed. On the eighth day, the virus from the latter had been employed in the vaccination of an elder brother, in whose case the evolution of the disease had been entirely regular.

In the case of the first child, however, deep ulceration had occurred, at the three sites of inoculation, with indurated edges, quite suggestive of indurated chancre; but the corresponding lymphatic ganglia were not engorged. On the same arm, however, was a perfectly cicatrized periostosis. The difficulty was shown of establishing the influence of syphilis in a case which exhibited tertiary symptoms after a few weeks, without the occurrence of symptoms intermediate between these and the primary lesion. The reporter consequently assumed the phenomena to be manifestations of the strumous diathesis in a infant vaccinated very early after birth. Gubler added that he had seen many such cases in the Maison Municipale des Nourrices, and in the Maternité, resulting from vaccination at an early age (one day after birth). The absence of the color of raw ham was also noted in this instance.

Guntz (22) admits the fact that men formerly syphilitic may become fathers of children who are infected with the parental disease, and afterwards of those who are apparently healthy. This fact seems to support the view that the syphilis of the father was either cured or existed merely in the encapsulated centres of some authors, the results of specific treatment pointing in the same direction. But the author considers the theory of latent syphilis an "arbitrary hypothesis," without foundation in fact. The pathological anatomy of glands, with ducts whose lumen is unobstructed (when not actually inflamed and therefore plugged with disease products), is opposed to the theory of glandular encapsulation, as it points to an uninterrupted career in the process of disease. Symptoms occurring after so-called latency, indicate that there was

no cure, but merely interruption in the chain of external manifestations. The function of glands is continuous—and not occasional in its results. Syphilis may exist without external manifestations, and even without glandular complication, in such a condition of activity as to ensure syphilis of the child—such a child being really the sole symptom of the existing disease. And that this fact is of paternal rather than maternal significance, is evident from those cases where the treatment of the father only ensures favorable results, while the untreated mother may beget healthy children by another male. The products given up to the circulating fluids of the body by its diseased organs are living, and not comparable to the substances which, being swept mechanically through such fluids, eventually produce embolism. It is therefore not to be concluded that a succession of diseased, less diseased and finally healthy children is evidence of "latent" disease on the part of the male parent. Though in general this succession may be deemed of favorable import, still the sword of Damocles remains suspended over the head of both father and child. Only a prolonged and critical examination of children, with such antecedents, and reported as "healthy," can be regarded as conclusive. For both parent and child, there is no safe criterion of cure. Syphilitic recurrences, therefore, point to uninterrupted disease of the progenitor—a disease in which all symptoms may be wanting, save that found in the offspring. Experience has demonstrated that even involvement of the testis may co-exist with the procreation of sound children. Organs not macroscopially disordered, may be foci of disease for the interchange of nutritious and waste matters, an interchange which is necessarily continuous and simultaneous in all organs of the body. There is no fixed limit between health and disease.

The author's cases are urged in illustration of the foregoing statements; and he concludes with the suggestion that many suppurously obstinate disorders of the skin in infants and older children, may be made to yield to appropriate anti-syphilitic treatment.

MR. HUTCHINSON'S (124) clinical remarks were suggested by a young woman, 17 years of age, having the teeth and physiognomy of hereditary syphilis, absolutely deaf in both ears, the exceptional feature being the degree of surdity. This symptom, in such cases, is usually sudden and unattended by inflammatory symptoms, pain, discharge or otoscopic lesions. As rapid amaurosis often follows syphilitic optic neuritis without pain or external evidence of inflammation, so the aural symptoms may depend upon obscure changes in the auditory nerve. No post-mortem examinations have ever been made. Subjects of inherited syphilis surviving the period of childhood, are usually tenacious of life. In syphilitic deafness the mercurials and iodides are of no decided value. In a minority of cases, patients become absolutely and permanently deaf; in others, the function is seriously deranged; in a third group of cases, almost complete recovery results. Though it is not clear that treatment and recovery stand in the relation of cause and effect, it is safe to use mercury with caution, never pushing it to such an extent as to produce depression.

The third of the *Bellevue Hospital cases* (26) was that of a child aged two years, exhibiting a tubercular syphiloderm, double periostitis of the tibiæ, and cachexia, first affected at the 3d month, and, subsequently, well illustrating the efficiency of sound treatment. It served as a text for the visiting physician (who was evidently a disciple of the Ecole du Midi), inasmuch as, although the mother had never exhibited the slightest evidence of constitutional syphilis, yet because she had given birth to a syphilitic child, she was adjudged to be infected. He therefore dwelt upon the question of unrecognized syphilis in mothers ("imperceptible syphilis" of Diday), but did not explain why the behavior of the disease was, in such cases, so exceptionally different from that universally recognized as classical.

The case reported by JACOB (27) was that of a sixteen-year-old girl, ailing for six months, and having an obscure previous history. There had been cervical adenopathy, and one month before admission to hospital, she had suddenly lost power in the left side. Two months before, sudden deafness supervened.

On admission, she was found greatly emaciated, forehead low, occiput raised, nose flattened, teeth specifically altered. Interstitial keratitis had completely destroyed vision on the right side, and partially on the left. Hearing was gone. The voice was harsh and low—she moaned as if in pain. There was partial impairment of sensibility of the left arm and leg, with complete loss of power, slight wasting of muscles, no facial paralysis, tenderness on percussion over lower dorsal spines (but no perceptible prominence in that region), cough without expectoration, deficient resonance and flattening of left apex, with moist râles universally, enuresis and mental hebetude. One month afterward, left hemiplegia also occurred, and she lay in bed completely unable to stir a limb. Treatment by the iodides, from May 22d to Oct. 4, resulted in such improvement that she could stand and even walk with the help of an arm.

MASON (28), *à propos* of Diday's Paper on "Syphilis by conception," reports the case of an apparently cured syphilitic man, the father of healthy children, who married a second time. The second wife first miscarried with suspicious symptoms, then had a syphilitic child, and, finally, in the second month of the next pregnancy, showed symptoms of syphilis, the father, at the same time, suffering from a fresh explosion of that disease. A case is also reported, from details furnished by Dr. Loomis, of New York, in which a syphilitic father married a healthy wife, and had two healthy children. Then the wife miscarried with an infected fœtus, the husband suffering from a relapse and the wife from symptoms of constitutional disease. Then followed pregnancy and miscarriage, with periosteal disease, pachymeningitis and paralysis of the mother. The argument is that, as the maternal syphilis did not occur till after the inception of pregnancy, therefore it resulted from the latter. We remark of such cases, that they serve merely to establish the possibility of infection within certain periods of

time, and that the explosions of paternal disease might be effectively used as an argument on both sides of the vexed question.

Monti (29) sketches the macules, papules, pustules, coryza, condylomata and ulcers of hereditary syphilis. He adds that splenic tumor at birth is a constant phase of the disease, a statement which is certainly incorrect. It is probably true of one half of all examined cases. (For exception, cf. post mortem lesions in case examined by Parrot, *Lyon Medical*, Feb. 6, 1876, p. 213.) Monti is also at variance with other observers in recognizing rachitis and scrofulosis as sequelæ of hereditary syphilis. In the way of therapy, he recommends calomel, ferric lactate, ferric iodide, baths of corrosive sublimate, and, as local applications (condylomata, &c.) red precipitate and lime water, with mercuric bichloride. Dietetic rules are also given which, in particular, enjoin the avoidance of the starches, and the use of soups at the third and fourth month—the best practical advice in the lecture.

Parrot (30) finds the study of hereditary syphilis of special interest, because it may be conducted from the inception of the disease, and declares that the latter is neither congenital nor infantile syphilis, nor yet the syphilis of the newly born, but is strictly inherited from either father or mother. He gives a brief resumé of the researches upon the question, dividing the authors upon the subject into two classes, one embracing the names of Gaspard, Trélla and Marfaid, the other including Fallopius, Angier Ferrier, Rondelet, Ambroise Paré, Rosen, Madon and Bertin.

Dr. Drysdale's *Review of the Debate at the Pathological Society of London*, (31) contains a note of his own report of the case of a girl, aged 16 years, the subject of inherited syphilis. She had tracheal stenosis, destruction of the soft palate, and a large phagedenic ulcer on the lower extremity. This girl had cavernous breathing, cavernous râles and bronchophony in the supra spinous fossa of the left side. All these symptoms yielded to the potassic iodide. He also refers to Lancereaux's case of a woman, aged forty, with peculiar teeth and other symptoms of hereditary syphilis, in whose right lung there was a large cavity occupying all three lobes. The apex was found crepitant, and no trace of tubercle was discovered, many parts of the lung being indurated. All this was adduced to show that true syphilitic phthisis did occur in hereditary syphilis.

Dr. Greenfield also reported a case of recognized syphilitic pneumonia in a newly-born child.

Taylor (32) supplements Barlow's observations, given above, by describing similar lesions in two cases of congenital syphilis treated by him in the Evelina Hospital. Inflammatory globular swellings, in these cases, discharged a thick, green, ropy pus and healed with small cicatrices, strikingly different from boils or gummata. From a few, "black blood" escaped, others were resolved. He quotes Bouchut (Gaz. des Hôpitaux, Aug. 1, 1876), who describes small, hard, subcutaneous nodules, softening but not bursting for months, and then giving exit for a long time to a scanty yellowish

sanious pus, through a livid and fistulous opening. Taylor's cases were evidently affected with congenital syphilis, but the phlegmonous syphilides, after exit was given to the pus, healed more readily than those described above.

The article published as an *editorial in the New York Medical Record* (33), is evidently from the pen of an expert. On the questions relating to the pathology of visceral syphilis in the hereditary form, reference is made to the enlargement of the spleen exhibited by Dr. Barlow, traceable as low as the crest of the ilium. The child had been observed since its fourth month, when the splenic disorder became evident with the usual symptoms of the disease. A systolic murmur was audible at the cardiac apex and as far as the axilla. According to Gee, the splenic involvement occurs in one half of the cases, one fourth of which terminate fatally. Little is known of the lesion. Capsular thickening has been noted, without lardaceous or gummatous changes. Reference is also made to the specimens exhibited by Gowers, from a twelve-year-old child affected with hereditary syphilis. These were two coalesced nodules, springing from the dura-mater, composed of rounded, nucleated cells, $\frac{1}{2000}$ to $\frac{1}{3000}$ of an inch in diameter, with fusiform cells and delicate fibrillary stroma.

A description is also given of Barlow's specimens from a female infant seen by him, having snuffles, but no rash, though the father was known to be syphilitic. He learned three months later that the child had had convulsions, and he noted wasting and serpiginous symmetrical syphilodermata. Later it had laryngitis and contractions of the feet. In the fundus of each eye, were specks of brownish exudation in the choroid. Post-mortem, the thoracic and abdominal viscera were found normal, but in the skull were adhesions of arachnoid and dura-mater, with some greenish lymph. The pia-mater was thick and fibrous, and in some places, its vessels were thickened and appeared like white threads. There were no granulations and but few superficial spots of softening. Examination of the choroid membrane by Mr. Nettleship, showed collections of corpuscles in the chorio-capillaris, not arranged around the vessels.

"These growths in the choroid differ from tubercle, in not being, like it, of peri-vascular origin, and in not showing a tendency to caseation, as the latter does. In the pia-mater there was a great excess of fibrous tissue, and a diffuse infiltration of nucleated lymphoid cells, while the vessels showed a growth in their inner and middle coats of such extent as to nearly occlude them. When they become thus occluded, new vessels develop in their structures."

35. **Ambrosoli, C.**—On the use of tincture of tayuga of the Ubicini brothers. Case of infantile syphilis. Gazz. Med. Ital. Lombard., Ser. VII., T. III., No. 49, p. 481.

36. **Daniel.**—On the influence of anti-syphilitic treatment on the mother, and on the product of gestation. Thèse de Montpellier, No. 74, 1876. (Gazette des Hôpit., p. 359, April 19, 1877.)

37. **Faraoni, M. L.**—Tayuga in syphilis and scrofula. Re-

port to the Medical Congress in Turin, Sept. 18–23, 1876. S. Muggiani & Co., Milan, 1876.

38. **Gallassi, R.**—The tincture of tayuga of the Ubicini brothers. Giorn. Ital. d. Malat. Vener. e. d. Pel. Oct., 1876. (*Gazz. Med. Ital. Lombard.*, S. VII., T. IV., p. 481.)

39. **Ilanor, Carl Sigmund von.**—On new methods of treatment in syphilis. 4to. Urban und Schwarzenberg. Vienna, 1876.

40. **Johnson, G. K.**—Preventive treatment of congenital syphilis. Detroit Med. Journal., p. 344, May, 1877.

41. **Longhi, G.**—The tincture of tayuga of the Ubicini brothers. *Gazz. Med. Ital. Lombard.*, S. VII., T. III., No. 48, p. 471.

Ambrosoli (45) treated a child, two years of age, who had been infected with syphilis while at the breast. It had syphilodermata with inguinal and cervical adenopathy. A gramme of the tincture of tayuga was injected hypodermically. No reaction ensued, and the therapy was successful.

Faravot (37) has collected the records of those Italian physicians who have treated syphilis and scrofula with the tayuga tincture. As regards hereditary syphilis, he cites the cases reported by Longhi and Ambrosoli, and adds two others, mentioned in a letter from Prof. Bellazzi of Bologna. One child had purulent conjunctivitis and vesicular syphilodermata; the other suffered from ulcerative lesions of the mouth and external genitals. The results, in each case, were quite doubtful so far as regards the value of the medication.

Jouvenis (40) reports two cases, in each of which, treatment of the pregnant wife was followed by the birth of healthy children, though both parents were diseased. The remedies employed were blue mass, mercuric bichloride and the potassic iodide—the two last were given with bark.

Longhi (41) treated a child, three months old, infected from the breast of a nurse, having papular syphilides of the mouth and genitals. One hundred and fifty drops of dilute tincture of tayuga were added to 8.25 grammes of water, and three teaspoonfuls of the whole given daily, the solution being also applied locally to the lesions. A rapid cure is said to have resulted.

SYPHILIS OF THE MOUTH, THROAT AND LARYNX.

GEORGE M. LEFFERTS, M. D.

1. **Chauval.**—Syphilitic caries of the ethmoid bone, purulent infiltration of the anterior lobes of the brain. Bull. de la Soc. de Chir. Paris, p. 714, 1876.

2. **Cripps.**—A case of fœtid discharge from the nose (syphilitic ozœna), treated by a new operation. London Lancet, May 5, 1877.

3. **Fournier.**—On tertiary syphilitic glossitis. La France Méd., Aug. 26; Oct. 7–14; Nov. 15–22–29; Dec, 2–9, 1876.

4. **Hausen.**—A case of paralysis of the abductor muscles of the vocal cords, of syphilitic nature—cure. St. Petersburgh Med. Wochensch. No. 6, 1876.

5. **Hugonneau.**—A clinical study of interstitial syphilitic glossitis. Gaz. Hebdom., p. 173, March 16, 1877.

6. **Martel.**—On laryngeal syphilis. Thèse de Paris, No. 59, 1877. Le Progres Méd., p. 216, March 17, 1877.

7. **Mauriac.**—On naso-pharyngeal syphilis. L'Union Med., March 22–29; April 26. Continuation of Feb. 24. March 1–13, 1877.

8. **McDowell.**—Tracheotomy and its advisability in certain forms of syphilitic disease. Med. Press and Circular, p. 243, March 28, 1877.

9. **Symian.**—A contribution to the study of tertiary syphilis of the larynx. Thèse de Paris, No. 17, 1876.

10. **Tauber.**—Ozœna syphilitica. Cincinnati Lancet and Observer, Dec., 1876.

11. **Von Vajda.**—Sarcoma of the nose in a syphilitic subject. Wiener Méd. Presse, March 18, 1877.

12. **Verneuil.**—A case of adhesion of the free border and the postero-superior aspect of the velum to the posterior pharyngeal wall, the result of syphilitic ulceration. Operation, improvement. Bull. de la Soc. de Chir. de Paris, Tome II., p. 308, 1876.

13. **Wagner.**—On syphilis of the nose and larynx. Ohio Med. Surg. Journal, June, 1876.

Cripps' case of *syphilitic ozæna* is as follows: A. B., aged 30, struck the bridge of her nose five years ago in falling. The nose remained tender and swollen for two or three months, and the nasal passages became so much obstructed that she was scarcely able to breathe through them. Six months after the injury a fœtid discharge commenced. At the time of examination the nose was flattened, and both nostrils reduced to little more than pin-hole apertures. The soft parts between the nose and upper lip were deeply ulcerated, and the fœtor arising from the discharge was beyond all description. The probe, introduced with difficulty, detected no dead bone. Ordered to take full doses of iodide of potash and wash out the nasal cavities with Condy's fluid. Two and one half months later, as dead bone could be felt with the probe and the patient was anxious that something should be done to relieve her, she was operated upon by drawing up the upper lip and nose together with the soft parts forming the anterior portions of the face, after liberating the former by an incision between it and the upper alveolar process of the jaw. The nasal fossæ were thereby thoroughly exposed, and a large quantity of dead bone, which could both be seen and felt, was easily removed by the finger and forceps. The operation was completed by replacing the lip in its natural position. The wound healed by first intention. All discharge ceased, the ulcerations healed, and the fœtor entirely disappeared.

The doctor remarks that this method of operating is of the greatest importance and value, and would seem justifiable in cases of ozæna which, according to recent observations, are dependent in a large majority of instances on a sequestrum or carious portion of bone, even if an examination fails to detect it.

McDowell,[83] in his interesting paper, states that the question as to the advisability of performing tracheotomy in syphilitic disease of the larynx often becomes one of life or death, and that no class of cases are calculated to cause more anxiety to the surgeon, and in certain instances to require more vigilant treatment. He has met with two instances of death as the result of laryngeal spasm caused by destructive syphilitic ulceration extending down to the larynx, and in the face of such experiences does not doubt but that cases are met with in which tracheotomy becomes a positive necessity. In support of his position he quotes Bryant as saying, that when ulceration has commenced and seems to be unaffected by general treatment, the subject of tracheotomy claims serious consideration; for, unless the organ of voice and respiration can be kept quiet, repair will not go on. As long as progressive ulcerative disease exists, a sudden spasm of the larynx is imminent, and also the death of the patient. The operation should, however, only be undertaken when the disease is steadily progressing in spite of treatment, and it is clear that the larynx will be destroyed as a vocal as well as a respiratory organ, unless some steps be taken to stop its progress, and of these steps there are none equal to tracheotomy; for all surgeons are familiar with the fact that even under the most extreme conditions of disease repair goes on in the larynx directly the tube has been introduced and physiological rest is given to the organ. Holton, speaking upon the same subject, expresses himself as follows: In chronic laryngitis cured by tracheotomy, the cure is not effected by opening the larynx but by giving the larynx rest. The operation is performed in reference to these two circumstances, in reference, first, no doubt, to securing the continuance of life by allowing the patient to breathe through the tracheal tube; secondly and ulterially, the object is to give rest to the diseased part. In the performance of tracheotomy for disease of the larynx, the surgeon never touches the disease at all, he merely enables the patient to breathe through the tracheotomy tube and diverts the stream of air away from the larynx, thus giving the latter an opportunity of recovering itself.

In conclusion, McDowell states that the two forms of syphilitic ulceration of the larynx in which tracheotomy is called for, are either of the phagedænic or serpiginous type, and that a distinction must be drawn between them. The former is much the most common, and will be found to pronounce itself generally in naturally weak and broken-down subjects. It is rapid and destructive in its progress, after eroding the cartilages of the larynx. It requires active local as well as general treatment. The margin of this form of ulceration is sharply cut, and there is no surrounding thickening of the tissues. The serpiginous form, on the other hand, most com-

monly occurs, when it does present itself (which is rarely), in strong, healthy individuals, and is much slower in its progress, and carries before it an effusion of specific lymph, its edges thickened, irregular, and of lupoid character. It is in the phagadenic that large doses of iodide of potassium and iron, combined with opium and liberal diet, will prove most serviceable. In the serpignious form of ulceration, the best results are to be obtained, he believes, from the judicious administration of a carefully sustained course of mercury.

In regard to the pathology of laryngeal spasm, he regards it as being caused, in the phagadenic variety of ulceration, by exposure of the recurrent laryngeal nerve; whereas in the serpiginous it is probably the result of pressure upon that nerve, or of pressure and ulceration combined, as sometimes happens in cases of malignant disease.

Dr. Von Vajda showed at a recent meeting of the medical society of Vienna (11), a man, aged 24, who had had syphilis three times. Seven months ago he had a tumor as large as a pigeon's egg on the septum nasi. It was supposed to be a syphilitic gumma, especially as there were nodes on the tibiæ and other indications of syphilis. About two months since (after an absence of two months) the patient returned. The swelling was somewhat smaller, but was covered with numerous fungoid excrescences as large as hempseeds, which bled readily. Careful rhinoscopic examination showed that the tumor could not be defined sharply posteriorly; and the microscope showed that its substance consisted of small and large round cells, along with some spindle and giant cells, with numerous nuclei. Some of these cells had undergone mucous degeneration like that observed by Wagner and Virchow in gumma. The doctor diagnosed the tumor as a sarcoma, and Doctor Heschl confirmed the diagnosis. He pointed out the difficulty of diagnosis in such cases, and remarked that in gumma the connective tissue elements rarely showed signs of proliferation, also that in malignant growths the cells, and in gumma the inter-cellular substance, were the chief seats of mucous degeneration.

Verneuil reports the following interesting case (12): The patient was a young woman, married, 22 years of age, who had contracted syphilis since her marriage, and about a year afterwards had suffered great loss of substance of the soft palate, which resulted in a nasal tone of voice and painful and imperfect deglutition; after a while the projection of the velum posteriorly became evident, and there were all the signs of closure of the posterior cavity of the nasal fossæ: the patient could not blow her nose or breathe unless the mouth were open. She had intermittent deafness, and examination showed that the velum was completely fastened to the pharyngeal wall. Verneuil decided to operate, and proceeded as follows: The patient was anæsthetized, and the channel which remained between the pharynx and the nasal fossæ was enlarged by the knife. A pair of polypus forceps was then introduced and their blades strongly opened, while the lateral adhesions

were broken down by means of the fingers. He then placed between the velum and the pharynx an india-rubber apparatus consisting of two lateral tubes, and of a series of transverse smaller ones, the anterior openings of the larger tubes passing out through the nostrils and the posterior through the mouth, opposite the labial commissures; but it was found necessary to remove the instrument, as after some days specific ulceration showed itself wherever it was in contact. Verneuil had then recourse to progressive dilatation by means of a sound ending in a rubber bag, which was introduced by the nostrils and inflated. By repeating this process daily, it was hoped to prevent adhesions forming, but the negligence of the patient frustrated the perfection of the idea; nevertheless a sufficient aperature was formed, by means of which the patient could breath and blow her nose, the sense of smell returned, and the nasal character of the voice was noticeable only during rapid utterances and in a loud tone.

During the subsequent discussion of the case, Champion*ière* remarked that on a similar occasion he endeavored to introduce a hollow sound from behind forwards, but after two hours' attempt, being unable to do so, he made lateral incisions to effect his object, but notwithstanding the employment of india-rubber laminæ, adhesion still took place. At a second operation he cut down with a single stroke into the nasal fossæ behind the velum, the wound healed, but the patient had been forced to wear a silver tube through the nasal fossæ.

Wagner, speaking of secondary *syphilis of the nose* (13), says, that with other symptoms of syphilis existing, or a clear history of the disease in the individual, the diagnosis is easily made, but without these, there is nothing that will enable us to pronounce upon the true character of any given case. To explain further, he remarks that the discharge, thickened mucous membrane, superficial ulceration, pain, etc., are precisely what you find in ordinary catarrh or stroma, and in such cases if proper local treatment had been previously tried for a reasonable length of time, without good result, he would then put the patient under specific treatment. He has done this in a large number of cases in which the history of syphilis was extremely doubtful, and the good results therefrom convinced him that he had not erred, he therefore asserts that very many of the obstinate cases of so-called nasal and naso-pharyngeal catarrh are of specific origin.

Secondary syphilis of the larynx generally appears within a few weeks or months after the primary symptoms, simultaneously with the early skin and mouth affections, or later, but never precedes them. The subjective symptoms do not differ from those of an ordinary laryngeal catarrh; among the objective symptoms, is the mucous patch, which the author in one paragraph says are *occasionally* observed, while in another remarks that the mucous patch will be found, in the *large majority* of cases, to co-exist with others in the pharynx or on the tonsils, tongue or soft palate. This latter statement is interesting in a view of the wide difference of opinion

regarding their occurrence and frequency in the larynx, at present prevailing among observers.

Tertiary syphilis of the larynx is characterized, according to our author, by extensive and deep ulcerations, appearing usually in the following order. 1st. Upon the free edge and posterior surface of the epiglottis. 2d. Upon the vocal cords, and ventricular bands. 3d. The arytenoid cartilages and inter-arytenoid fold.

Finally, after summarizing the opinions of several writers upon the points in differential diagnosis between laryngeal syphilis and cancer and tuberculosis of that organ, and giving the results of his own observation, he concludes with the following statistics, regarding the frequency of the affections, considered in his paper. At the London Throat Hospital, 40–50 per cent of all cases treated, were syphilitic. At Guy's Hospital 40 per cent were syphilitic; the laryngoscopic clinic at Vienna treated in 3 years 3,700 cases of throat disease, of these 120 were laryngeal syphilis. At Charity Hospital, Blackwell's Island, of 55 cases of constitutional syphilis, 32 had tertiary symptoms and 23 secondary; of the 32 cases of tertiary, 20 had laryngeal syphilis, and in the 23 cases of secondary, 19. At the Metropolitan Throat Hospital, out of 1,000 cases, 74 were syphilitic; of these 27 laryngeal, 21 nasal, and 26 pharyngeal.

DISEASES OF THE PENIS, URETHRA AND TESTICLES.

E. L. KEYES, M.D.

1. **Bourgade.**—Diabetes as a cause of phymosis. Le Prog. Méd., Sept. 2, 1876. (New York Med. Record, p. 728, Nov. 11 1876.)

2. **Demarquay, J. N.**—Surgical maladies of the penis. Paris. A. Delahaye, 1877.

3. **Dittel.**—Treatment of hypertrophy of the prostate. Centralblatt f. Chirurgie, Nov. 27, 1876. (Phil. Med. Times, Oct. 14, 1876, p. 8.)

4. **Foot, A. W.**—Papilloma of the bladder with protracted hematuria. Brit. Med. Journ., Sept. 30, 1876. (Phil. Med. Times, p. 65, Oct. 28, 1876.)

5. **Griffith, G. De G.**—New treatment for phymosis (by gradual dilatation, pushing the glans penis through the contracted preputial orifice). Brit. Med. Journ., Oct., 1876. (Half Yearly Comp. Med. Sci., p. 550, Jan., 1877.)

6. **Johnson, J. T.**—New (?) method of performing circumcision (slitting prepuce on dorsum and cutting off sides). Atlanta Med. and Surg. Journ., July, 1876.

7. **Lucas, R. C.**—Thrombosis penis. The Practitioner, p. 22, Jan., 1877.

8. **Ory, E.**—Treatment of preputial (genital) herpes. La France Méd., p. 21, Jan. 10, 1877.

9. **Ranke, H.** Posterior catheterism. Deutsche Med. Wochenschrft, No. 29, 1876 (Monthly Abstract Med. Sci., p. 567, Dec. 1876).

10. **Roberts, J. B.**—Exstrophy of the bladder; new method of operating, etc. Phil. Med. Times, April 1, 1876, p. 322.

11. **Stukowenkoff, N.**—Case of urethral calculus. Centralblatt f. Chirurgie, No. 43, 1875.

12. **Taylor, Melville.**—Fibroid tumor of prostate successfully treated by injection of iodine. Virg. Med. Monthly, June, 1876.

13. **Walker, M. M.**—Case of persistent priapism. Virg. Med. Monthly, p. 784, Feb., 1877.

14. **Wilkerson, T. B.**—Case of hypospadias cured by operation. Virg. Med. Monthly, p. 795, Feb., 1877.

Bourgade (1) refers to the irritation produced by saccharine fluids upon portions of integument with which they come into contact (vesicular and papular eruptions seen upon workmen in sugar factories). He recounts four cases of phymosis due to inflammation produced by the irritating action of saccharine urine upon the prepuce and glans penis. Verneuil had seen two similar cases, and a surgeon is alluded to who lost two cases upon which he operated. The deduction is, do not operate on phymosis in any case of possible doubt without examining the urine for sugar.

Demarquay's posthumous work (2) is published by Voelker and Cry. It contains many curious cases and much interesting matter, but is not quite so full in some particulars as it would have been had its author lived to finish it. It deals with 1, Physical Lesions of the Penis; 2, Inflammatory Lesions; 3, Tumors and Organic Lesions; 4, Anomalies (including stricture of the urethra).

Deffel (3) has produced acute prostatitis and suppuration by the use of parenchymatous injections of iodine as advised by Heine for prostatic hypertrophy.

Ranke (9) brings the experience of another case of posterior catheterism to add to one previously published (from Volkmann's clinic) in No. 6, Deutsche Medicinische Wochenschrift. In the new case no guide would pass by the urethra. The stricture had long been closed and a catheter had been permanently established in the bladder through the hypogastrium. By this opening a firm flexible catheter was easily passed through the prostate into the urethra and up to the posterior face of the stricture, rendering very simple the operation of dividing the stricture from without, an operation which might otherwise have been attended by all the difficulties so well appreciated by those who have attempted external perineal urethrotomy without a guide.

Roberts (10) reports a case of exstrophy of the bladder from the service of Dr. Levis. The novelty of the operation consisted in an attempt first to establish drainage downwards by an artificial urethra leading from the base of the bladder into the perineum; secondly, to shut in the bladder entirely in front. The patient died, there being considerable suppuration around the flaps and ante-mortem clots in the heart cavities.

15. **Chiene, John.**—Note on the treatment of gleet. Med. Times and Gaz., June 24, 1876, p. 686.

16. **Dauphin.**—Gonorrhœal ophthalmia. La Presse Méd. Belge, Sept. 24, 1876, p. 337.

17. **De Vos.**—Anti-blennorrhagic injection. L'Union Méd,. p. 24, Jan. 6, 1877.

18. **Dixon. J. N.**—Urethro-ragia; ergot as a styptic. Cincinnati Medical News, Nov., 1876. (Half-yearly Compendium of Med. Sci., p. 550, Jan., 1877.)

19. **Guillaud.**—Manifestations of rheumatism in the urethra and bladder. Lyon Méd. (La Presse Méd. Belge, Nov. 5, 1876.)

20. **Marty.**—Gonorrhœal endocarditis. Archives Gén de Méd., Dec. 1876, p. 660. (Med. Times and Gaz., Dec. 23, 1876, p. 710.)

21. **Merkel, S. B.**—Oil of sandal wood in the treatment of gonorrhœa. Phil. Med. Times, April 29, 1876, p. 367.

22. **Rucker.**—Bromide of potassium in gonorrhœa. Western Lancet, June, 1876. (Half-yearly Comp. of Med. Sci., Jan. 1877.)

23. **See.**—Digitalis in the treatment of urethritis; digitalis an aphrodisiac, etc. Tribune Méd. de Paris. (La Presse Méd. Belge, Sept. 10, 1876, p. 323.)

24. **Taylor, Chs. Bell.**—Remarks on gonorrhœal ophthalmia. Med. Times and Gaz., April 1, 1876, p. 360.

25. **Van Holsbeck.**—Anti-blennorrhagic injections. L'Union Méd., p. 271, Feb. 15, 1877.

26. **Will, J. C. Ogilvie.**—Note on the treatment of gleet by isolation. Med. Times and Gaz., Oct. 14, 1876, p. 435.

Dixon (18) claims that injections of fluid extract of ergot into the urethra will arrest severe hæmorrhage from that canal without forming a clot. His conclusions are drawn from one case.

Guillaud (19) recognizes a gonorrhœal rheumatism and a rheumatic gonorrhœa as well. To support the latter he adduces five cases of urethral discharge which he thinks he proves to be due to an existing rheumatic attack. In a similar manner he endeavors to create a rheumatismal cystitis—but with poor success.

Marty (20) bases his paper on gonorrhœal endocarditis upon a case under the care of Prof. Poncet. He gives a good résumé of the several cases already reported in different periodicals. The new case is a young man of 22, with no rheumatic antecedents, who had an attack of gonorrhœa running a moderate course from Aug. 15 to Sept. 22. At this date chills and headache came on, the urethral discharge moderated, and a systolic murmur appeared upon the fourth day. Among his conclusions Marty maintains that endocarditis occurs as a result of gonorrhœa as frequently as pericarditis, if not more often.

See (23) recommends with confidence a combination of digitalis and iodide of potassium in the treatment of cases of great sexual excitability with tendency to hypochondria, etc.; where, for

instance, erection and ejaculation are produced by the sight, touch or thought about one of the opposite sex. He relates a striking case.

STRICTURE OF THE URETHRA, ETC.

27. **Adelina, Ch.**—Strictures of the urethra and internal urethrotomy. La France Méd., p. 813, Dec. 16, 1876.

28. **Bos, A.**—Rapid dilatation of strictures of the urethra. Thèse de Paris, 1876. (La France Méd. p. 802, Dec. 9, 1876.)

29. **Browne, J. W.**—Case of retention of urine depending upon organic stricture of the urethra, necessitating puncture of the bladder above the pubes and per rectum. The Dublin Journ. of Med. Sci., Feb., 1877.

30. **Bush, J. F.**—Two cases of stricture of the urethra. Bost. Med. and Surg. Journ., Nov. 30, 1876, p. 637.

31. **Byrd, W. A.**—Sloughing of scrotum and perineum: recovery. Bost. Med. and Surg. Journ., Nov. 9, 1876.

32. **Caswell.**—Fifteen cases of stricture. Bost. Med. and Surg. Journ., Nov. 30, 1876.

33. **Cras.**—Traumatic lesions of the urethra. Gaz. Hebd., p. 810, Dec. 22, 1876.

34. **Croly.**—On urethral stricture with enlarged prostate and cystitis. The Dublin Journ. of Med. Sci., Jan. 1, 1877.

35. **Curtis, T. B.**—Recent progress in genito-urinary surgery. Bost. Med. and Surg. Journ., Nov. 30, 1876, p. 640.

36. **Dick, H.**—The subcutaneous and other methods of dividing strictures of the urethra. Med. Press and Circular, p. 39, Jan. 17, 1877.

37. **Harrison, R.**—Stricture of the urethra. Lancet, p. 247, Aug. 19, 1876.

38. **Le Fort, L.**—New method of treating strictures of the urethra, immediate progressive dilatation. L'Union Méd. and La France Méd., p. 745, Nov. 15, 1876. (Lyon Méd., p. 503, Dec. 3, 1876.)

39. **Monette, G. N.**—Traumatic stricture of the urethra. Am. Practitioner, p. 224, Oct., 1876.

40. **Ormsby, L. H.**—Recto-vesical fistula, lacerated urethra. Medical Press and Circular, March 29, 1876, p. 258.

41. **Otis, F. N.**—Spasmodic stricture of seventeen years' duration, cured by over-distension of the membranous urethra, combined with division of a contracted meatus. Archives of Clinical Surgery, p. 222, Dec., 1876.

42. Stricture of the urethra; progressive dilatation; rare accident; recovery. La Presse Méd. Belge, Nov. 5, 1876. (Moskaner Med. Zeitung., Nos. 14 and 16, 1876. Centralblatt f. Chirurgie, p. 576.)

43. **Teevan.** Internal urethrotomy and its advantages. Lancet, 1876. (Half-yearly Comp. of Med. Sci., p. 549, Jan., 1877.)

44. **Teevan.**—Traumatic stricture of the urethra and numerous penile fistulæ, cured by internal urethrotomy. Lond. Clin. Soc. Rep., Med. Times and Gaz., Oct. 28, 1876.

45. **Teevan.**—Choice of an operation for stricture of the urethra., Med. Times and Gaz., p. 357, April 1, 1876.

Byrd (31) details a case of extensive sloughing of the scrotum and perineum, unusual in being spontaneous, without obvious efficient cause. There was no injury and no infiltration of urine. The patient recovered.

Cras (33). Discussions in the Société de Chirurgie (the highest exponent of the surgical views of France), of Dec. 13th, 1876, and May 19th, 1875, on contusion of the perineum, crushings of the urethra, &c., disclose the painful fact that not one member of the society on either occasion raised his voice *against* the advisability of leaving a "sonde à demeure" in the urethra after the operation of external perineal urethrotomy. In favor of this proceeding the following names are found; Cras, Notta, Guyon, Rochard, Le Fort; while Duplay, Trélat, Verneuil, and Voillemier had nothing to say to the contrary.

Le Fort's (38) new method of treating strictures may, perhaps, be new in France, but it has no essential feature of novelty in it. A small conducting soft instrument, with metal cap, is passed through a tight stricture and allowed to remain there twenty-four hours. At the end of that time it lies loosely in the canal, a conical instrument of metal is screwed upon the conducting guide, forced in, and withdrawn, to be followed by another of larger size.

Ormsby's (40) cases are interesting. In the first a vesico-rectal (small) fistula got well spontaneously after Ormsby had dilated a stricture of the urethra, and thus allowed the bladder to empty itself without violent contraction. The second case was one of lacerated urethra treated by a rubber catheter à demeure. The patient made a prompt recovery.

Otis's case (41) is one of those rare examples of prolonged spasmodic stricture which are so apt to pass for some other and more serious lesion. The prompt effect of over distension in this case is gratifying. Dr. Otis considers that the condition is analogous to vaginismus, in which latter malady the beneficial effect of over distension is notorious.

Teevan (45) comes out strongly in favor of cutting as against divulsion in urethral stricture.

DISEASES OF THE TESTICLES, ETC.

46. **Coombs, C. P.**—Case of severe orchitis following paracentesis. Med. Press and Circular, Feb. 23, 1876, p. 156.

47. **Depaul.**—Cancer of the testicle in an infant of ten months. Soc. de Chirurg, May 19, 1876, p. 316. Phil. Med. Times, July 8, 1876, p. 470.

48. **Knaggs.**—Treatment of orchitis with arnica. Gazette Méd. de Rome. (La Presse Méd Belge, Aug. 13, 1876.)

49. **Leale.**—Tubercular diseases of testicles. N. Y. Path. Soc. The Med. and Surg. Reporter, July 1, 1876.

50 **Leclaire.**—Practical considerations with regard to acute orchitis, and the advantages of compression in its treatment. La Presse Méd. Belge, Nov. 5, 1876, p. 385.

51. **Thiry.**—Compression in acute orchitis. Presse Méd. Belge, No. 5, 1876., Med. Times and Gaz., Nov. 18, 1876, p. 579.

52. **Thiry.**—Hemorrhagic orchitis; its causes, varieties, lesions, consequences, and treatment. La Presse Méd. Belge, Nov. 26; Dec. 3, 17, 1876; and Jan. 14, 1877.

53. **Trelat.**—Diagnosis of tumors of the testicle. Le Prog. Méd., Jan. 10, p. 41; and Feb. 10, 1877, p. 103.

54. **Volkmann.**—Treatment of hydrocele of the testicle by incision with antiseptic dressings. Berl. Klin. Wochenschrift, Jan. 17, 1876, p. 29.

55. **Waterman, L. D.**—Treatment of orchitis. Practitioner, Nov. 1876, p. 334.

56. Puncturing the testicle in orchitis. The Med. and Surg. Reporter, Feb. 17, 1877.

Kearns (48) cures (?) epididymitis with arnica by keeping the patient in bed fifteen days.

La Cleale (50) and Thiry (51) praise the application of evenly adjusted pressure to the testicle from the very onset of an acute attack of epididymitis.

Volkmann (54) makes an exceedingly good showing with his seventeen cases of hydrocele treated by incision antiseptically. He says that no febrile reaction followed, that the cases got well on an average in ten days, and that many of the later patients were discharged in eight days, generally leaving the bed on the fifth or sixth day; surely a most excellent result. All the cases recovered, and in sixteen out of the seventeen the cavity of the tunica vaginalis was found to be obliterated on the first changing of the bandage, not one drop of secretion having formed. In the one exceptional case a small portion of the cavity remained, and serum collected in it. A drainage tube was therefore introduced and removed in a few days, whereupon the little cavity immediately closed.

The operative procedure is as follows: The genitals and groins are carefully and frequently washed with carbolic acid solution, the hairs shaved off. Under carbolic acid spray the hydrocele is incised from top to bottom, and its cavity syringed out with a 3 per-cent solution of carbolic acid. Bleeding vessels are tied with catgut, which is cut short. The serous membrane is stitched to the skin all around with many points of fine suture. A portion of the front wall of the tunica vaginalis may be cut away if it be thickened. Antiseptic gauze is firmly applied, a hole being left for the penis. All defects in the dressing are stopped up with salicylized wool.

Reviews and Book Notices.

Atlas of Skin Diseases. Part II. Acne rosacea, Ichthyosis, Tinea versicolor, Sycosis non-parasitica. By Louis A. Duhring, M.D., Professor of Skin Diseases in the Hospital of the University of Pennsylvania; Physician to the Dispensary for Skin Diseases, Philadelphia, etc. Philadelphia, J. B. Lippincott & Co., 1877.

In the July issue of last year we noticed the first part of this admirable work; the present fasciculus has been published several months, although behind the time expected: future portions are promised more regularly. The second part fulfils completely the expectations raised by the first one, and the plates are models of artistic worth, guided by intelligent and experienced medical judgment; they are thoroughly true to nature.

Plate I.. of Acne rosacea, represents the disease in a far more aggravated form than is commonly met with but, with the descriptive text no mistake in diagnosis could be made. We agree wholly with the author in applying the term acne rosacea to such a state as here exhibited; the congestive element of the disease is well represented, as also the enlarged capillaries: it is rare, we think, in such cases to find so many comedones as appear here. Some of the larger masses, we think, pertain more to the variety acne indurata, as do also the scars, which are rare in uncomplicated acne rosacea; it is not uncommon to find these two varieties combined, acne rosacea and indurata.

Plate II. of Ichthyosis is a most admirable presentation of the disease, and no one could fail to diagnose a case after having once studied this picture.

Plate III. represents the very common eruption, Tinea versicolor, named also pityriasis versicolor, sometimes wrongly called chloasma or liver spots. The general delineation of the disease is perfect, and the plate is one which should be carefully observed by all, for the eruption is constantly mistaken and treated for syphilis. The color of the diseased spots is a trifle yellow,—a shade more of brown would have imitated the disease more closely.

Plate IV., of Sycosis non-parasitica, is especially to be commended: these cases are constantly treated as "barber's itch" (and to their great detriment) by the most irritating parasiticides. A careful study of this portrait and the letter press will assist almost any one to arrive at the correct diagnosis.

Again we must compliment and thank Dr. Duhring for this American Atlas; we have nothing but praises for it, and only hope that it will find its way into the hands of every physician in this country.

Hebra on Diseases of the Skin. (Lehrbuch der Hautkrankheiten. Band II. Lief III.) Stuttgart: Ferdinand Enke, 1876.

It is with sincere pleasure that we announce the completion of Hebra's great and classical work on Diseases of the Skin, begun in 1860, the concluding Lieferung bears the date of 1876. The first volume was revised in 1874, and the two earlier portions of this second volume appeared in 1872 and 1874 respectively; and in the two volumes before us, of 733 and 735 pages respectively, we have a total of 1468 pages of the best descriptions of skin diseases extant, and a monument of literary work of which Dermatology may well be proud. The latter portions of this work have emanated from Kaposi, who has long been associated with Hebra, and represent very well the present standpoint in regard to the actual knowledge of skin diseases: latterly microscopic drawings have been introduced. The earlier portions being familiar to our readers we will notice now but the closing section which appeared a few months since.

This concluding part embraces the diseases included in the last three divisions of Hebra's classification: X., Cutaneous ulcers, XI., Cutaneous neuroses, and XII., Cutaneous parasites and their diseases. "Cutaneous ulcers" refer principally to the hard and soft chancre, and here, as might be expected, we have expressed the unitist views of Kaposi (of course in accordance with those of his master, Hebra), indeed the larger part of this section devoted to the subject is a verbal transcription from the illustrated work of Kaposi (*Die Syphilis der Haut und der Angrenzenden Schleimhäute*), pages 27 to 62 of this latter, corresponding almost exactly to pages 506 to 526 of Hebra, with some omissions.

The section on "Neuroses cutaneæ" is short, occupying but twenty pages in the 258 of this Lieferung, but is quite full in references to the literature of the subject. We are sorry not to see the matter of the eruptions following injuries and disease of nerves worked up, but very slight allusion is made to it, and herpes zoster, the neurosis *par excellence*, having been treated of in the earlier part of the work, does not enter this class.

More than one half of this Lieferung is occupied with the parasitic diseases, and is a thorough and masterly study of them. The substance of quite a portion of the general considerations in reference to the present stand point in regard to the vegetable parasitic diseases has been given to our readers in full in the April issue, pages 229–244. The microscopic drawings of the vegetable parasites are very good, although the delineations are, we think, far more clear than can be generally recognized clinically, and thus might mislead those unaccustomed to microscopic study.

It is a satisfaction to the dermatological world to have this great work of Hebra's finished, and it must and will long stand as an authority in this branch; its clinical descriptions will ever remain true because they are from nature, but its therapeutics must become old, and, for this country at least, will be altered with the advances of the science of Dermatology. As a work of reference, especially in regard to bibliography, it will probably never be excelled.

The Tonic Treatment of Syphilis. By E. L. Keyes, A.M., M.D., Adjunct Professor of Surgery and Professor of Dermatology in the Bellevue Hospital Medical College, etc. New York: D. Appleton & Co., 1877.

THIS little work of Dr. Keyes' is valuable in its way, and if the knowledge contained in it were possessed by the profession at large there would be far fewer cases of severe and rebellious syphilis, and still fewer cases if practitioners knew better how to recognize syphilis in its protean forms.

We regret that this brochure bears evidence of having been hastily written; for the subject is one that demands very careful consideration, and we believe that many of the statements might mislead in regard to the purely tonic effect of mercury, and the readiness with which syphilis yields to treatment; still the influence of the work is most excellent, for to those unacquainted with the subject it gives good suggestions of practical benefit, while to those who have abused mercury it acts more or less as a check.

One very correct opinion, which we are glad to see in print, is as follows: "The Hot Springs of Arkansas are vaunted for their power to eradicate syphilis. *This claim is utterly unfounded in fact,*" and the author in a few words gives the reasons for the assertion. The *italics* are ours, and are inserted to emphasize a matter about which frequent inquiry is made, and about which our clinical experience has long ago decided in the same manner.

On the Pathology and Treatment of Gonorrhœa. By J. L. Milton, Surgeon to St. John's Hospital for Diseases of the Skin. London: 1876.

LIKE all the writings of Mr. Milton this book is of a practical character, and although it is rather diffuse contains very much of good. The opinions of others are introduced very freely, and would be confusing were they not criticised and at the end of each section the author's opinion clearly stated. The rules for treatment are judicious, and in the main such as are of well recognized value by writers on the subject.

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(A number of unforeseen circumstances have caused that present issue much beyond its regular time of appearance; it is hoped that such delays may be unnecessary in the future. Ed.)

ARCHIVES

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EDITED BY

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EDITORIAL.

A special Journal, devoted to a branch of medicine which has been so much neglected as Dermatology by the profession at large, must create for itself a position, and command its own audience, which it must in a measure educate up to its standard; this of course refers only to the general practitioners, who have not devoted any special thought or study to the branch.

The aim of the ARCHIVES OF DERMATOLOGY has been to meet the wants of the General Practitioner, and to serve as a means of communication between the specialist, whose whole time and thought are devoted to Skin or Venereal Diseases, and those in general practice, that the daily-gained experience of the latter may reach the former. To this end the Editor and staff have endeavored to include within its pages reference to everything which has been reported elsewhere in these departments during the year, in addition to the large amount of original matter which has filled more than one half of the Journal. Many of the original articles have undoubtedly been very special in their character, and considerable of the matter digested from other Journals has been purely scientific, but it must be borne in mind that it is impossible to render the entire subject of Dermatology clear and interesting to those unacquainted with more than its rudiments, and that the Archives is designed to serve as a compendium of knowledge in this branch for those engaged exclusively in it, as well as an assistant to the general practitioner in managing these diseases.

Attention is especially called to the very large number of references to Dermatological literature contained in the Review and Digest departments. Vol. I. contained six hundred and thirteen references; Vol. II. seven hundred and sixty-eight, and in Volume III. the number reaches eleven hundred and forty-five. It is believed that this record is unique, and that no branch of medicine has ever been thus thoroughly presented to the medical public, and that the indices of these volumes are unequalled for fulness of reference.

The Editor has continued the serial articles entitled "*Clinical*

Conversations on Diseases of the Skin," and the "*Notes on the Local Treatment of Certain Diseases of the Skin*," with a view of furnishing in each issue practical matter of immediate service to those little versed in Dermalotogy ; they will be continued as long as they continue to meet with the favorable reception which has been accorded to them in the past.

With the beginning of Volume II. it was found necessary to enlarge the capacity of the Journal, and accordingly it was printed much more closely—entirely without leads ; the gain thereby made was equivalent to sixteen pages in each issue, or sixty-four pages of solid reading matter during the year. In Volume III. the press of matter has been still greater, and in addition to the gain from close printing, the present number contains twenty-two additional closely printed pages, or one hundred and eighteen pages in all. It is hoped that the pecuniary support of the Archives will warrant the continuance of an increase in the actual size of the Journal. Space will also be gained in future issues by a new arrangement of the matter in the Digest Department, whereby the titles of articles which are not abstracted will be printed in smaller type and so condensed as to occupy but a small portion of the space heretofore required for them. Certain changes will also be made in the conducting of the Journal, aiming to furnish more accurately an account of the progress of Dermatology, and therapeutical and other hints of general service.

For these and other reasons the first issue of Volume IV. may be delayed much beyond the usual interval of time, and it may be deemed advisable to make the new volume begin with the coming year ; should this occur, the indulgence of our readers is asked.

AMERICAN DERMATOLOGICAL ASSOCIATION.

We look forward with interest to the coming First Regular Annual Meeting of this newly formed Association, which is to meet at Niagara Falls on September 4th. There is every indication that the attendance will be large for such an organization, and that much of interest will be there presented.

By a provision of the By-Laws titles of papers to be read must be forwarded to the Secretary not later than one month before the time of meeting.

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